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ABSTRACT

Summarized are the findings and recommendations of a 2-year study of all major mental health, and mental retardation, alcohol, and drug abuse services and programs in Nevada. Fourteen chapters are given to the following topics (sample subtopics are in parentheses): description of the survey (scope of the project); summary and recommendations (problems with present services); the mentally handicapped population (population projections and analysis); Direction, an information-based service (problems with the Direction service in Nevada); (prevention of mental health disorders, mental retardation, and alcohol and drug abuse); identification (common problems with identification); special education and training services (needed improvements); nonresidential mental health services (children's behavioral services); treatment for alcohol and drug abuse (problems in the current delivery system); residential mental health and mental retardation services (medical facilities with psychiatric units); vocational services (private community vocational centers); medical services (private medical insurance); residential living (adult group care and family care facilities); and income assistance (county income assistance programs). Appendixes include information on vocational rehabilitation program and client characteristics, the Joint Commission on Accreditation of Hospitals, and California's Child Health and Disability Prevention Program.
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MENTAL HEALTH AND MENTAL RETARDATION SERVICES IN NEVADA

PREPARED UNDER A GRANT FROM THE MAX C. FLEISCHMANN FOUNDATION

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PREFACE

In the summer of 1973, as a result of numerous applications for grants in the field of mental retardation, the Max C. Fleischmann Foundation was considering having a research organization conduct a study of mental retardation services. In the fall of 1973, the Chairman of the Mental Health Care Facilities and Programs Subcommittee of the Nevada Legislature inquired if the Foundation would finance a broad study of the mental health and mental retardation service system in Nevada. The request received the support of the Director of the Nevada Department of Human Resources. As a result, the trustees of the Foundation elected to broaden the scope of the study to include all mental health and mental retardation services and service delivery programs in Nevada.

At the invitation of the Foundation, The Rand Corporation applied for and was awarded a grant to conduct such a study. After the grant award, The Rand Corporation conducted the study independently of the Foundation. All inquiries concerning the report, and requests for copies, should be directed to The Rand Corporation.

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The study, conducted over a two-year period ending in early 1976, describes the current status of services and service delivery programs for four different groups of mentally handicapped Nevadans, identifies major problems with present services and programs, and recommends solutions. The overall goal is to furnish information to the Max C. Fleischmann Foundation, to Nevada officials, and to the public, on what can be done to improve the quality and quantity of mental health and mental retardation services in Nevada.

ABSTRACT

At least 11,000 people with mental health disorders, at least 11,000 mentally retarded people, and at least 44,000 alcohol or drug abusers needed some type of substantial service in Nevada in 1975. This report summarizes the findings and recommendations of a two-year study of all major services and service delivery programs for these different groups of people. It describes all major public and private programs intended to meet their needs, documents problems with services and programs, and presents recommendations for improvement. Over 60 Nevadans were given the opportunity to review and comment on a draft of this report in early 1976 (including people responsible for every major existing service program) and to update material where any major substantive changes had taken place since the time of our original data collection.

Nevada's official goal for the Division of Mental Hygiene and Mental Retardation with respect to the delivery of services is to "strengthen the delivery system toward a full continuum of mental health and mental retardation services in the least restrictive environment possible, to ensure that needed services are available to all citizens, regardless of age, location, race, sex, creed, or income."

The \$35 million being expended annually in Nevada on services for different groups of people with mental health disorders, mental retardation, and alcohol and drug abuse problems is producing beneficial results. Service programs in the state have expanded and improved in recent years, and progress has been made toward achieving the official goal. Numerous major problems still persist, however. Many people are receiving no services, the wrong services, or inadequate services.

Major problems include insufficient service capacity in relation to need, inequitable distribution of services by geographic location, lack of coordination and direction of the service system, poor facilities, inadequately trained personnel in some programs and hence poor-quality services, failure to provide a full range of services, lack of a continuum of levels of intensity of service, failure to have a variety of treatment modalities available to match the variety of people's needs, and a deficiency of information needed for program management and evaluation of program effectiveness.

The report presents 71 recommendations for improving services to people in Nevada with mental health disorders, mental retardation, or alcohol or drug abuse problems. These recommendations are summarized in Table A, grouped by type of service and by three different levels of effort which government officials may choose to make to remedy the problems. The arabic number beside the summary of each recommendation in the table indicates the numerical order in which the complete detailed recommendation is presented in Chap. 2.

Even if there is to be only a slight increase or no increase in the level of effort, by which we mean a 5 percent or less increase in annual expenditures, many of the low-cost recommendations shown in Table A can be implemented. Our several recommendations on management practices and organizational structure, for example, can be implemented at little or no additional cost but can enhance the control, coordination, and performance of the service system. Better program management

Table A
SUMMARY OF AREAS OF RECOMMENDATIONS AND COSTS, BY DESIRED CHANGE
IN LEVEL OF EFFORT
(Fiscal Year 1974 expenditures = \$35 million)

Suggested Priority Areas of Recommendations by Desired Change in Level of Effort			
Slight or No Change		Modest Increase	Meeting All the Needs
Service Need	Estimated Annual cost increase of \$1.8 million (5 percent)	Estimated annual cost increase of \$16 million (46 percent); adopt all "slight or no change in desired level of effort" recommendations in each service need area, plus those listed below	Estimated annual cost increase of \$27 million (77 percent); adopt all "slight or no change" and "modest increases in desired level of effort" recommendations in each service need area, plus those listed below
Direction	1. Establish Regional Direction Centers 2. Strengthen state advisory boards		
Prevention	6. Assign specific responsibility for prevention of mental retardation		3. Expand genetic counseling with respect to mental retardation. 4. Ensure provision of immunizations, Rh desensitization and PKU screening 5. Expand family planning services, and create a high-risk registry for newborns
Identification		10. Provide behavioral and psychological screening once for each young school child 11. Screen high-risk groups for mental health disorders	7. Establish health and developmental screening of new school enrollees 8. Improve Medicaid early screening and follow-up 9. Expand Special Children's Clinics' mental retardation diagnostic services
Special Education and Training	13. Allocate special education funds by specific handicap and enforce current standards 16. Revise preschool program focus in Community Training Centers 17. Revise preschool program focus in Special Children's Clinics. 18. Increase referrals from schools to other service agencies 19. Obtain better information on special education and training programs	12. Increase the number of special education units funded 15. Provide appropriate special education and training to mentally retarded Nevada Mental Health Institute (NMHI) residents	14. Increase state special education technical advisory staff and provide technical assistance to rural counties
Mental Health Services	20. Fill authorized professional staff positions at the Las Vegas Mental Health Center 23. Increase Rural Clinics efforts for people with substantial mental health disorders 26. Revise the Las Vegas Children's Behavioral Services staff and the service focus 29. Provide specified staff mix and client focus in Children's Behavioral Services residential programs 34. Restrict use of Mentally Disordered Offender Facility to prisoners 36. Provide a physically secure mental health unit at NMHI 37. Revise the role of NMHI to fulfill four specified functions 38. Obtain better information on mental health programs	22. Upgrade rural mental health staff, and add part-time traveling service teams based at NMHI 28. Establish an upgraded mental health technician personnel classification and a university-based training program 31. Improve follow-up treatment of people released from residential mental health programs 32. Create programs to provide an intermediate level of mental health services over an extended time period for children and adults	21. Provide 24-hours-a-day emergency crisis-intervention services in mental health centers and Rural Clinics 24. Establish a second community mental health center in Clark County 25. Expand the Reno Mental Health Center into a full community mental health center 27. Provide mental health services to mentally retarded people if needed. 30. Correct major deficiencies in mental health services noted in the NMHI accreditation report 33. Establish halfway houses for people with mental health disorders 35. Provide specified mental health services in Nevada State Prison

Table A (Continued)

Suggested Priority Areas of Recommendations by Desired Change in Level of Effort			
	<i>Slight or No Change</i>	<i>Modest Increase</i>	<i>Meeting All the Needs</i>
Mental Retardation Services	40. Do not reduce existing NMHI mental retardation staff size when Desert Developmental Center opens 42. Consolidate state mental retardation program control by removing control of mental retardation services from the NMHI Director 44. Expand special education and training, as appropriate, for Eagle Valley Children's Home residents 46. Obtain better information on mental retardation programs	39. Improve the NMHI mental retardation program to meet JCAH accreditation standards 41. Provide the equivalent of the Desert Developmental Center services to northern Nevadans, but defer major facility construction 43. Improve training of state "Technicians" serving mental retarded people 45. Provide special services to mentally retarded prisoners	
Alcohol and Drug Abuse Services	47. Obtain better information on alcohol and drug abuse programs and prevalence rates 48. Streamline the organizational structure for alcohol and drug abuse programs	49. Create a comprehensive alcohol abuse treatment program for the Las Vegas area 50. Provide alcohol and drug detoxification services throughout Nevada 51. Establish rehabilitation houses for rural alcohol and drug abusers 52. Establish a full inpatient treatment program for drug abusers	
Vocational Services	53. Provide specified general vocational services in rural areas, with short-term more specialized services in urban areas for rural residents 55. Consolidate the Vocational Training program with specified vocational program 57. Increase referrals from Employment Security to the Vocational Rehabilitation program 58. Obtain better information on vocational service programs 59. Increase referrals from nonvocational to vocational service programs		54. Double the Community Training Center minimum funding per client 56. Provide vocational education for emotionally disturbed youth 60. Expand the Vocational Rehabilitation program or shift the caseload emphasis to serve more severely handicapped clients
Medical Services	61. Study the effects of mandatory mental health and mental retardation service coverage in private health insurance 62. Supplement state-operated program funds by billing private and public health insurance to extent feasible		
Residential Living Services	64. Establish standards for developmental homes and sheltered living apartments 65. Consolidate developmental home supervision responsibility	63. Double the size of the developmental home and sheltered apartment living programs	66. Implement standards and supervision for foster homes and Adult Group Care and Family Care Facilities serving mentally handicapped people 67. Refer mentally handicapped foster children for services as appropriate 68. Screen residents of Youth Services Agency facilities for mental handicaps, followed by services as appropriate
Income Assistance	70. Transfer mentally handicapped Aid to Dependent Children recipients to the Supplemental Security Income program, if they qualify.		69. Identify financial assistance recipients with mental handicaps, and refer for services as appropriate 71. Provide a state supplement to the SSI payments to mentally handicapped people

and service effectiveness information can be obtained. The client focus can be shifted in certain programs. And Regional Direction Centers, a key recommendation to improve coordination of the service system, can be established. To begin to resolve most of the major problems, however, expenditures and staff will have to expand.

If the level of annual expenditures is to be increased, we would add certain priority types of recommendations to those cited above for the "alight or no increase in level of effort." Recommendations listed in the "modest increase in level of effort" column of Table A are those which we feel address the greatest gaps in the range of needed services, the greatest deficiencies in service capacity in relation to need, and the most serious deficiencies in the quality of services that are now provided.

For people with mental health disorders, we assign priority to recommendations associated with identifying people in need of service by screening high-risk groups and screening each schoolchild once, expanding special education to serve all seriously emotionally disturbed children the law now says must be served, restructuring and expanding rural mental health services, providing improved follow-up treatment of people released from residential mental health programs, providing intermediate levels of mental health services to those needing them over an extended time period, and substantially upgrading the skills of mental health technicians.

For mentally retarded people, we assign priority to identification of people in need of service by screening each schoolchild once, increasing special education resources to serve all those children the law now says must be served, providing appropriate special education and training to mentally retarded Nevada Mental Health Institute residents, expanding developmental homes and sheltered apartment living opportunities in the community, providing the equivalent of the Desert Developmental Center's range and quality of services to northern Nevadans, improving the training of state "technicians" who serve mentally retarded people, providing special services to mentally retarded prisoners, and bringing the severely deficient mental retardation program at the Nevada Mental Health Institute up to standards of the Joint Commission on Accreditation of Hospitals.

For alcohol and drug abusers, we assign priority to recommendations dealing with the creation of statewide drug and alcohol detoxification services, of a comprehensive alcohol abuse treatment program in the Las Vegas area, of an inpatient drug treatment program analogous to the one for alcohol abuse treatment at the Nevada Mental Health Institute, and of a program for rehabilitation houses plus outpatient treatment in rural Nevada.

If Nevada officials approve an increase of approximately \$16 million in annual expenditures, or 46 percent above the FY 1974 level of effort, they will be able to implement all of the recommendations listed in the "modest increase in level of effort" column of Table A. They will not be able, however, to implement many other of our recommendations that we regard as necessary to resolve major service system problems.

If Nevada officials decide to make the effort required to meet all the needs of each different group of mentally handicapped people, then all the recommendations should be implemented. We estimate this would require an increase in annual expenditures of approximately \$27 million, or 77 percent above the FY 1974 level of effort. This is not inexpensive, but we believe it will be necessary if Nevada is to achieve its official goal for the mental health and mental retardation service delivery system. Despite recent improvements, great unmet and inadequately met serv-

ice needs still prevail. It is up to Nevada to say how far it is willing to go in meeting those needs.

The study is described and its findings and recommendations are summarized in Chaps. 1 and 2, respectively.

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The authors wish to thank the many people and organizations who lent their cooperation and assistance in the course of this study. Foremost is the Max C. Fleischmann Foundation, without whose support the study would not have been conducted. Senator Lee Walker and the joint subcommittee of the Nevada Legislature concerned with mental health and mental retardation care facilities and programs requested and provided public impetus for and endorsement of the study, thereby increasing the cooperation we received. Roger Trounday, in whose Department of Human Resources most mental health and mental retardation programs are administered, provided us with complete access to all program staff and all available information. We received excellent cooperation in our many interviews with both officials and direct service personnel in every major public and private service program in Nevada for mentally handicapped people. Dozens of program clients and their families also contributed their experiences and views, thereby adding a vital component to this study. As we think back over the study, we are gratified by this extraordinary cooperation and assistance.

Several Rand colleagues and consultants provided valuable assistance. Expertise in psychology, psychiatry, medicine, and special education, together with knowledge derived from extensive experience in delivering mental health and mental retardation services, were provided by our consultants Eli M. Bower, Arnold Milstein, Irving Philips, and Robert Rubenstein. Fred Blackwell analyzed computer-based information on Nevada programs. John Pincus, the manager of Rand's Education and Human Resources program, oversaw the progress of the study. Will Harris edited and significantly improved the comprehensibility of this report. Patricia Fleischauer and Velma Thompson reviewed and made helpful comments concerning earlier drafts of this report. Additionally, coauthor G. D. Brewer benefited from the environment and fellowship of the Center for Advanced Study in the Behavioral Sciences, Stanford, California, during the academic year 1974-75.

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Chapter 1

DESCRIPTION OF THE STUDY

This report describes the results of a two-year study of all major mental health and mental retardation services and service delivery programs for people in Nevada. In the summer of 1973, as a result of numerous applications for grants in the field of mental retardation, the Max C. Fleischmann Foundation was considering having a research organization conduct a study of mental retardation services. In the fall of 1973, the Chairman of the Mental Health Care Facilities and Programs Subcommittee of the Nevada Legislature inquired if the Foundation would finance a broad study of the mental health and mental retardation service system in Nevada. The request received the support of the Director of the Nevada Department of Human Resources. As a result, the trustees of the Foundation elected to broaden the scope of the study to include all mental health and mental retardation services and service delivery programs in Nevada.

At the invitation of the Foundation, The Rand Corporation applied for and was awarded a grant to conduct such a study. After the grant award, The Rand Corporation conducted the study independently of the Foundation. All inquiries concerning the report, and requests for copies, should be directed to The Rand Corporation.

Rand reports do not necessarily reflect the opinions or policies of the sponsors of Rand research. The Max C. Fleischmann Foundation is not responsible for the findings and recommendations of the study, and therefore this report should not be construed as indicating what action, if any, will be taken by the Foundation based on the information and recommendations contained herein.

SCOPE OF THE PROJECT

The study provides information on the size of the current and projected populations of various types of mentally handicapped people, information on the current status of services and service delivery programs for them, information on problems with present services and programs, and recommendations meant to solve those problems and hence improve mental health and mental retardation services throughout the state. The primary focus is on Nevadans of all ages who are afflicted with what are generally called mental health and mental retardation problems that result in a substantial need for special services. A secondary focus is on people with alcohol and drug abuse problems, since alcohol and drug abuse are considered by many to be special types of mental health problems. Major differences exist among those four types of mentally handicapping conditions mentioned above, and hence among service requirements of people afflicted with those different conditions. Consequently, major differences exist among our recommendations for programs to alleviate service problems for those four different groups of mentally handicapped people. We believe a single report provides a more unified perspective than would a separate report for each of those different conditions, however, because several programs in Nevada's current service system serve all four groups of mentally

handicapped people, and because the needs of the different groups are similar in some service areas. In general terms, the major service areas of concern to this study are: prevention of mentally handicapping conditions; identification of people with mental handicaps; direction to appropriate service providers; special education; treatment of mental health disorders; developmental training to ameliorate the effects of mental retardation; alcohol and drug abuse treatment; medical care; vocational services; residential care; and income assistance. The study is concerned with all service delivery programs in both the public and private sectors that serve mentally handicapped Nevadans.¹

The time-frame of concern in this study includes both the present and the next ten years. We chose a ten-year planning horizon because many major substantive program and facility changes require five to ten years for full implementation, and hence require planning now. It is both less essential and less feasible to plan fully for more than ten years in the future, because of uncertainties concerning Nevada's population growth beyond ten years, and because it is not necessary to make immediate decisions on most program changes that would take place so far in the future.

The scope of this project is necessarily large and comprehensive, because the service needs, programs, and problems of serving mentally handicapped people are also large and comprehensive. The literature in the field is vast, but researchers in nearly every phase of the field run up against the same persistent problem we encountered: a serious lack of data upon which to base definitive analyses. Hence, guarded provisos and caveats are often required. Because this is an overview study that must work with available data, it does not pretend to answer all questions.

RESEARCH APPROACH

We have taken a *policy-analytic, comprehensive view of the whole system serving mentally handicapped people* to enable us to assess the relationships of the system's constituent parts to its whole.² Admittedly, because we have chosen to be comprehensive, we may very well have erred in reporting or failing to report details about the service system's various components; we have worked diligently to minimize this possible problem.

We have also taken a *comprehensive, target-population view of the service needs of each different type of mentally handicapped population*, to enable us to identify the relationships among service needs and to assess how well the current and proposed service system policies are providing and will provide the mix of services needed by the target population.

In looking at the needs of mentally handicapped people, we found it essential to *disaggregate our analysis of the population by type and degree of handicap, by age, and by geographic location*, since needs and accessibility to the service system vary with those factors.

¹ We use the term "program" in a generic sense to describe a set of interrelated activities with some common unifying concept, such as delivery of a common service (e.g., a special education program), administration by a separate bureaucratic entity (e.g., the Vocational Rehabilitation program), or possession of a common goal (e.g., a program for preventing birth defects).

² For a more detailed description of our approach, see J. S. Kakalik et al., *Improving Services to Handicapped Children*, The Rand Corporation, R-1430-HEW, May 1974.

A series of questions that we posed and attempted to answer illustrate various facets of our research strategy:

- What are the *service needs* of each major subpopulation of mentally handicapped people?
- What are the characteristics of the *current service programs* for meeting those needs?
- What are the *objectives* of various participants in the service system, and how can progress toward the objectives be measured? (See the "Service System Goals" section of this chapter for a discussion of criteria on which the services and programs can be evaluated.)
- What are the *problems* with the present mix of services delivered and in the present structure of programs for achieving the objectives?
- What *recommended policy changes* appear desirable, at what costs, for alleviating problems and improving services?
- Depending on the level of expenditures officials decide to make and depending on objectives, what *priority* recommendations should be selected for implementation from the full set of recommended policy changes?

With the data at hand we can answer these questions only partially. We discuss the problems created by data deficiencies, and try scrupulously to identify assumptions, limitations, and the extent of data quality and reliability throughout the report.

We use a *multimethod approach*, for in an evaluation as complex as this, no single analytic method will suffice. The specific method used in any given case depends on the question at hand and the available data. Furthermore, the comprehensive, problem-centered approach we have taken is beyond the skill and endurance of any one person; it calls for *interdisciplinary* research. Our group includes people trained in policy analysis and evaluation, psychology, psychiatry, medicine, education, management, political science, sociology, and demography. Our staff and consultive specialists all came from outside Nevada and were independent of the state, to enable us to be as objective and unbiased as possible.

We used a *wide variety of information sources*. To gain an overview of the public and private system of services for mentally handicapped people, it was necessary to collect and analyze a great deal of information. The service system we found was fragmented, which implied that information about it would also be fragmented and that great effort would be required to collect and synthesize the data into a coherent picture. Our information came from several basic sources: interviews with officials responsible for overall service system policy; interviews with direct service personnel and administrators in every major service delivery program in Nevada and many small ones, including many whose primary purpose is not service to mentally handicapped people; interviews with dozens of clients of the service system and, in some cases, their families; interviews with organizations representing mentally handicapped people; program reports and unpublished information from service program data files; direct observations of services being delivered; literature in the various relevant fields; and consultation with professional experts. Finally, in early 1976, over 60 Nevadans were given the opportunity to review and comment on a draft of this report (including people responsible for every major existing service program) and to update material where any major substantive changes had taken place since the time of our original data collection.

THE MENTALLY HANDICAPPED POPULATION

People's degrees of mental health, mental retardation, or alcohol or drug abuse vary on a continuum in several dimensions. Those dimensions can be defined in terms of various types of functional capabilities, or various types of need for services. Consequently, any definition of a mental handicap must be rather arbitrary. Definitions used are not always consistent among service agencies, nor should they be, since an agency's definition of a particular handicap, used for establishing a client's eligibility for service, should be based on the potential client's need or functional capability as well as ability to benefit from the particular service or services offered by the agency. Chapter 3 of the main text presents various definitions used in Nevada and the best definitions available in Nevada and nationally for each type of mental handicap, along with a discussion of various estimates of the prevalence of each type of mental handicap. Citations to the relevant literature are provided in that chapter for those readers who may wish to pursue the issues of definitions and prevalence rates.

For the purposes of this study, we broadly define a mentally handicapped person as a person with a significant mental impairment that substantially limits his or her functioning in one or more major life activities, and results in a substantial need for special services that nonhandicapped people do not require. Need for service is a relative and not an absolute concept. The admittedly vague term "substantial need for special services" is meant to indicate that the population of concern in this study consists of those people that the majority of society would believe clearly require services. As mentioned at the beginning of this chapter, the study focuses primarily on people afflicted with what are generally called problems of mental health and mental retardation, and secondarily on people with problems of alcohol and drug abuse. Our occasional use of the shorthand generic term "mental handicap" refers to people with one or more of these four problems who need service, but in no way assumes a commonality of need for particular services by so widely diverse a group. The needs of people whose primary problems are with other types of mentally related handicaps, such as cerebral palsy, epilepsy, Parkinson's disease, and stroke, are equally important but beyond the scope of this study.

Nevada is a mountainous and semiarid state of approximately 110,000 square miles, with a northern border about 400 miles long, and with eastern and western borders about 500 and 600 miles long, respectively (see Fig. 1.1). The Federal Government controls 87 percent of the land in the state. The state's total population was about 573,000 in 1974, and Rand's best estimate is that it will grow to about 759,000 by 1985 (see Chap. 3 of the main text for the method of estimation). The population is clustered primarily in two metropolitan areas. The Las Vegas metropolitan area in southern Nevada has about 56 percent of the population. The Reno metropolitan area in northwestern Nevada has about 24 percent of the population, and the remaining 20 percent is in the large, sparsely populated rural counties. The map of the state shown in Fig. 1.1 contains the estimated 1974 general population by county.

Estimates of the number of mentally handicapped people in the state vary widely depending on the definition used, the data accepted, and the type of service for which the definition is to be used in establishing eligibility. Although we are not fully satisfied with the reliability of the estimates we present, we are confident that they represent the correct order of magnitude of those groups of people requiring

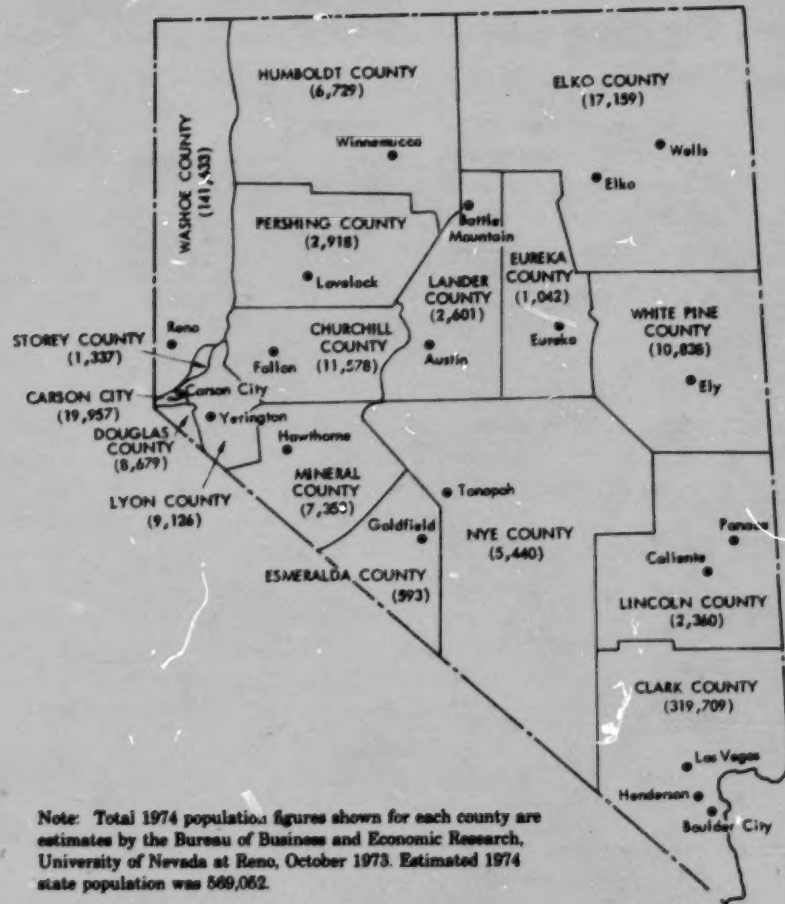


Fig. 1.1—Nevada population by county (1974)

at least some of the special services described in this report. Our approach has been to develop a range of credible estimates of the prevalence of each disorder, using the best available data in Nevada and nationally, and then to use the *minimum* estimate in the range throughout the report; that way we are reasonably sure that at least the specified number of people need service, and that program service capacity below that level is insufficient to meet the need.

Using the low prevalence estimate for each mental disorder yields a conservative total of at least 66,000 people who needed some type of substantial services in Nevada in 1975 because of mental disorders; the minimum number in need of services will grow to an estimated 89,000 by 1985, assuming the percentage of mentally handicapped people in the general population is the same in both years. Of the 1975 total, we estimate that at least 11,000 people had mental health disorders, at least 11,000 were mentally retarded, at least 33,000 were alcohol abusers, and at least 11,000 were drug abusers. If we were to use the upper rather than the

lower end of our range of estimates of prevalence for each type of disorder, the estimated *maximum* number in need of some services is about 122,000 in 1975 and 163,000 in 1985. Of the 1975 total, we estimate that a maximum of 55,000 people had mental health disorders, a maximum of 17,000 were mentally retarded, and a maximum of 37,000 were alcohol abusers. We did not estimate the maximum number of drug abusers, because of lack of data.

Definitions and prevalence information for each of the types of mental handicaps are summarized next.

Mental Retardation

The most widely accepted definition of mental retardation, both in Nevada and nationally, is "substantially subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period."³ Adaptive behavior refers to how proficiently the person functions in society; the developmental period extends up to age 18; and substantially subaverage means an IQ test score at least two standard deviations below average (i.e., an IQ score of approximately 70 or below). Using a relatively low estimate of prevalence of 2 percent of the population yields a prevalence of approximately 11,000 retarded Nevadans in 1975 and 15,000 in 1985 (assuming our best estimate of the total Nevada population in 1985). Using the most widely quoted estimate of prevalence, 3 percent of the population, yields a prevalence of approximately 17,000 in 1975 and 23,000 in 1985. (See Chap. 3 of the main text for sources of those estimates.)

Alcohol and Drug Abuse

There are no universally accepted, precise definitions for either alcoholism or drug addiction. The legal definition of an alcohol or drug abuser in the Alcohol and Drug Abuse chapter of the *Nevada Revised Statutes* is "a person whose consumption of alcohol or other drugs, or any combination thereof, interferes with or adversely affects his ability to function socially or economically."⁴ In spite of the definitional and empirical difficulties, however, at least an order of magnitude estimate of the size of the alcohol and drug abuse problem is needed to enable intelligent planning of service programs.

The two techniques in widespread use at the present time for estimating rates of alcoholism or alcohol abuse are based on: (1) deaths due to cirrhosis of the liver (a disease associated with heavy alcohol consumption); and (2) a statistical analysis of alcohol consumption data per capita (to estimate the number of people who regularly drink more than the equivalent of five ounces of ethanol, absolute alcohol, per day). A close correspondence exists between estimates of Nevada's alcoholism rate based on consumption and on liver cirrhosis deaths (8.8 percent of the general population compared to 7.8 percent). Because cirrhosis is a long-term disease that usually does not lead to sudden death, the cirrhosis death rate is most likely a characteristic of the resident population, with few occurrences among nonresidents,

³ American Association of Mental Deficiency, *A Manual of Terminology and Classification in Mental Retardation*, monograph supplement to the *American Journal of Mental Deficiency*, 3d ed., Washington, D.C., 1973.

⁴ *Nevada Revised Statutes*, 459.010.

and hence probably leads to a more accurate estimate for Nevada residents. Nevada has the highest rate of alcohol abuse of any state in the country, a rate that yields an alcoholic or alcohol abuser population over age 15 in 1975 of at least 33,000 (using the lower estimate, the cirrhosis-based rate of 7.8 percent). Projecting these figures to 1985 yields an estimated 44,000 people in the alcoholic or alcohol abuser population.

Drug abuse, as the term is used in this report, includes abuse of opiates, hallucinogens, stimulants, depressants, and other dangerous drugs as defined in Chap. 453 of the *Nevada Revised Statutes*.

It is even more difficult to estimate drug abuse rates than it is to estimate alcoholism rates. Few diseases are associated specifically with drug addiction, as liver cirrhosis is with alcoholism. Even deaths caused by overdoses of certain drugs cannot necessarily be attributed to addiction. Moreover, since the drugs are illegally produced or purchased, there are no gross quantitative data on usage rates analogous to per capita alcohol consumption. Using Nevada survey results as the best available estimate, opiate and other dangerous drug abusers (as distinct from drug users) numbered approximately 11,000 in 1975 and are projected to number approximately 15,000 in 1985 (assuming the percentage of drug abusers in the general population is the same for both years). See Chap. 3 of the main text for a discussion of these and other estimates.

Mental Health

The difficulties of defining and measuring the prevalence of mental retardation and alcohol abuse pale in comparison with those associated with defining and measuring mental health.

As defined in the *Nevada Revised Statutes*, "mental illness" means "any mental dysfunction leading to impaired ability to maintain oneself and function effectively in one's life situation without external support."⁵

The Nevada requirement for involuntary court-ordered admission and emergency admission to a mental health facility is that a person "has demonstrated observable behavior the consequence of which presents a clear and present danger to himself or others, or presents observable behavior that he is so gravely disabled by mental illness that he is unable to maintain himself in his normal life situation without external support."⁶ An emotionally disturbed child is defined as someone aged 2 to 17 years

whose progressive personality development is interfered with or arrested by a variety of factors so that he shows impairment in the capacity expected of him for his age and endowment:

1. For reasonably accurate perception of the world around him;
2. For impulse control;
3. For satisfying and satisfactory relations with others;
4. For learning; or
5. For any combination of the above.⁷

⁵ Ibid., Chapter 437, as amended by Senate Bill 374, Sec. 19, Nevada Legislature, 1975.

⁶ Ibid., Sec. 22.

⁷ Ibid., Sec. 14.

For purposes of this study, we consider a person to have primarily a mental health problem if he or she has a substantial need for psychological or psychiatric services primarily due to a mental disorder other than mental retardation or alcohol or drug abuse. Of course, people with primarily mental retardation or alcohol or drug abuse problems may also need psychological or psychiatric services, but such people are considered separately in this report. Thorough evaluation of each client is desirable, however, since more than one disorder may be present; for example, a drug abuser's primary problem may be a severe psychological disorder. The term "substantial need" is meant to indicate that the population of concern in this study consists of those people the majority of society would believe clearly require mental health services. The term "mental health problems" will include primarily the problems of people in five of the American Psychiatric Association (APA) categories: virtually all psychotic people, but only people with the more severe disorders within the categories of organic brain syndrome, neurosis, personality disorder (not due to alcohol or drug abuse), and transient situational disturbances. (See Chap. 3 of the main text for APA definitions of those categories.)

The question then is how one estimates the prevalence of need for substantial psychological services in Nevada. The answer is that one cannot do so accurately. The best we can say is that the prevalence is on the order of 2 to 10 percent of the population based on national data presented in Chap. 3 of the main text, and that 2 percent is probably a conservatively low estimate. We could also resort to a variety of indicators. Although the annual suicide rate is not an unambiguous indicator of the rate of mental health disorders in a population, the two rates are related. In 1973, the latest full year for which statistics are available, the annual rate of suicides per 100,000 population was 12.0 nationally and 22.3 in Nevada. Thus, as suggested by one measurable scale at least, the prevalence of mental health disorders in Nevada may be above the national average. Using the minimum 2 percent figure for the prevalence of mental health problems in Nevada yields an estimate of about 11,000 people in 1975 and about 15,000 in 1985. Using the maximum 10 percent figure yields an estimate of 55,000 people in 1975 and 75,000 people in 1985.

SERVICE SYSTEM GOALS

Having considered the nature and size of the mentally handicapped population in Nevada needing some type of substantial service, we now turn to the issue of goals for the service delivery system. We note a similarity in the stated goals of various service system participants in Nevada. We also note a tendency for goals to be stated in rather general terms, such as to "ensure needed services are available to all citizens." Since need is a relative and not an absolute concept, to be most useful such goals should be and often are operationalized with detailed statements of the characteristics of people eligible for services, and estimates of the number of people with those characteristics. See Chaps. 3 to 14 of our main text for details that make the following goals more operational.

The official state goal for the Nevada Division of Mental Hygiene and Mental Retardation with respect to delivery of services is to "strengthen the delivery system toward a full continuum of mental health and mental retardation services in the

least restrictive environment possible, to ensure that needed services are available to all citizens, regardless of age, location, race, sex, creed, or income."⁸

The concept of "normalization" as a goal of the service system is often heard in Nevada with respect to mental retardation, although it is more general. Normalization has been defined in various ways; one definition, stated in terms of mental retardation, is "making available to the mentally retarded patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society"; another definition, more generally stated, is "utilization of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviors and characteristics which are as culturally normative as possible."⁹

The state goal for the Nevada Bureau of Alcohol and Drug Abuse is "to provide a network of services for the prevention of addiction, treatment, and rehabilitation of the chemically addicted."¹⁰

The Nevada Developmental Disabilities Council¹¹ has pledged to work for "the protection of the rights of every individual who, by reason of being classified as developmentally disabled, is in any way restricted in his liberty or otherwise deprived of his human and civil rights by any external authority and the development and utilization of a full range of services and resources for the individual with a developmental disability. . . ."¹²

From our discussions with handicapped people, their families, and organizations supporting their cause, we surmise that if mentally handicapped people were to set goals for the service system, those goals would be consistent with the stated goal of the Nevada Division of Mental Hygiene and Mental Retardation, the objectives of the Nevada Developmental Disabilities Council, and the concept of normalization. In reality, however, these goals have been attainable only for selected individuals because serving all mentally handicapped persons requires a financial commitment that the state and society in general have not been willing to make. Governor Mike O'Callaghan and the Nevada Legislature have demonstrated agreement with the above-stated goals through their actions in approving expansion and improvement in services to mentally handicapped people in recent years, including 1975. However, state officials have other important program goals that can conflict with and prevent complete fulfillment of goals for improving services to mentally handicapped people. For example, Governor O'Callaghan, in his inaugural address in January 1975, set forth a fiscal goal that limits all state expenditures: "I will ask no new general taxes or increases in existing general taxes during the 1975 legislative session," a restatement of a pledge made at his first inauguration in 1971.¹³ The actions of the Nevada Legislature demonstrated agreement with the Governor on this fiscal goal. As a consequence, not enough resources have been available to

⁸ Office of the Governor, *State Goals*, State of Nevada, Carson City, Nevada, March 1, 1974.

⁹ Wolf Wolfensberger et al., *The Principle of Normalization in Human Services*, National Institute of Mental Retardation, Toronto, Canada, November 1972.

¹⁰ *State Goals*.

¹¹ Mental retardation is one major type of developmental disability.

¹² Nevada Developmental Disabilities Council, *Principles of Policy and Action*, Carson City, Nevada, May 29, 1974.

¹³ Governor Mike O'Callaghan, in his inaugural address in Carson City, Nevada, on January 6, 1975, as reported in "Governor: No New Taxes or Increases," *Nevada State Journal*, Reno, Nevada, January 7, 1975.

permit full achievement of the goals of the mentally handicapped population and the primary state agencies that serve them.

Multiple measures are required for assessing service system performance in relation to complex goals. Because we are dealing with complex goals, it is useful to consider a set of dimensions on which services and programs can be measured and evaluated:

- Effects on the quality of life of the mentally handicapped person, and of other people in his or her social orbit
- Future economic effects
- Equity of service distribution to the population
- Protection of civil and human rights of mentally handicapped people
- Sufficiency of service capacity in relation to need
- Quality of services available
- Degree of coordination of the service system
- Availability and accessibility of a full range of types of needed services
- Availability and accessibility of a continuum of levels of intensity of service
- Availability and accessibility of a range of treatment modalities to match the range of people's needs
- Current costs—resources consumed

While these goals and dimensions are laden with words requiring value judgments, they are nonetheless useful in evaluating service policy options. In general terms, enhanced performance of the service system on all but the last dimension or measure is desirable in helping to achieve the mentally handicapped population's goals and the stated goal of the Nevada Division of Mental Hygiene and Mental Retardation. The last measure listed—current costs—indicates the current resources consumed to achieve enhanced performance on the other dimensions. These dimensions are discussed in some detail in Chap. 8 of the main text under the heading "Desirable Features of a Service System."

The difficulty is that basic information is necessary before one can use those multiple measures to make comparative judgments about policy options in relation to goals. The application of those measures to Nevada is restricted by the deficient data available, especially on service effectiveness. Great precision should not be expected. With the available data, often all one can say with any confidence is that such-and-such a policy change would result in "major quality-of-life improvement" or "low cost relative to future economic benefits," or "filling a gap in needed services." Nonetheless, that may be enough. A sound policy choice can often be made if such general statements are known to be valid.

STRUCTURE OF THIS REPORT

The remainder of this report is divided into two parts. The first part consists of an overview of the study's recommendations (Chap. 2) for improving services to people with mental health disorders, mental retardation, or alcohol or drug abuse problems. The second part contains a detailed description of the mentally handicapped population (Chap. 3), followed by our detailed findings and recommendations for major types of service needs: direction to appropriate service providers

(Chap. 4); prevention (Chap. 5); identification (Chap. 6); special education and training services (Chap. 7); nonresidential mental health services (Chap. 8); treatment for alcohol and drug abuse (Chap. 9); residential mental health and mental retardation services (in separate sections of Chap. 10); vocational services (Chap. 11); medical services (Chap. 12); residential living (Chap. 13); and income assistance (Chap. 14). Within each chapter, services for people with mental health disorders, mental retardation, and alcohol or drug abuse problems are discussed separately whenever their needs differ.

Chapter 2

SUMMARY AND RECOMMENDATIONS

INTRODUCTION

This chapter summarizes the findings and recommendations of a two-year study of all major mental health and mental retardation services and service delivery programs for people in Nevada. By conservative estimates, at least 11,000 people with mental health disorders, at least 11,000 mentally retarded people, and at least 44,000 alcohol or drug abusers needed some type of substantial service in Nevada in 1975.

We have arrived at recommendations for improving services to these very different types of mentally handicapped people, beginning with their basic service needs. A client's specific service needs will depend on such factors as type and severity of mental handicap, age, previous services received, and others. The different basic service needs considered in this study are:

- Prevention of the mentally handicapping condition
- Identification of the mental handicap
- Direction to appropriate service providers
- Special education
- Treatment for mental health disorders
- Developmental training and other services to ameliorate the effects of mental retardation
- Alcohol and drug abuse treatment
- Medical care
- Vocational services
- Residential care
- Income assistance

Our research strategy, as outlined in Chap. 1, involves taking a comprehensive view of both the service system and the population needing service. We estimate the size and service needs of the four different types of mentally handicapped people, and analyze the characteristics of all major public and private Nevada service programs for helping to meet those needs. We consider the objectives of various participants in the service system, and several dimensions on which to measure progress toward those objectives. We then describe problems with the current service system, and present recommendations for resolving those problems and approaching the official state goal for the mental health and mental retardation service delivery system. Finally, considering the anticipated costs and effects of each recommendation, we suggest priorities for which recommendations to select for implementation from the full set of recommendations. Those priorities are suggested as a function of three different levels of expenditure effort Nevada officials may decide to make in resolving current problems and improving services.

In early 1976, over 60 Nevadans were given the opportunity to review and comment on a draft of this report (including people responsible for every major

existing service program) and to update material where any substantive changes had taken place since the time of our original data collection.

This chapter summarizes public and private expenditures for services to mentally handicapped Nevadans; discusses problems with those programs; summarizes our recommendations in each area of service need; and, in the last section, suggests priorities on implementation of our recommendations according to three different levels of expenditure effort state officials may choose to make to remedy the problems. Chapters 3 to 14 of the main text present the detailed data and analysis.

TOTAL SERVICE EXPENDITURES AND STAFF

Programs providing services to mentally handicapped Nevadans spent more than \$35 million in FY 1974, as shown by type of service in Fig. 2.1. The number of full-time-equivalent staff providing those services was about 1150. Refer to Chaps. 4 to 14 of the main text for sources of these data by type of service. We have not summed the number of people served by all programs because one cannot meaningfully do so with the available data; people often are served by more than one program in a year, with the result that adding the numbers served by all programs entails an unknown amount of multiple counting.

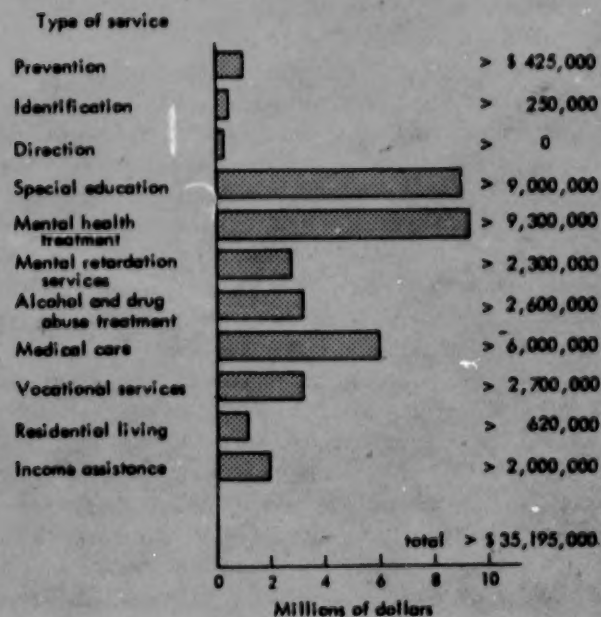


Fig. 2.1—Estimated FY 1974 expenditures for mentally handicapped Nevadans

Later sections of this summary discuss each type of service separately and present available data on expenditures, staff, and numbers of people served by each different type of mental handicap (mental health disorder, mental retardation, and alcohol or drug abuse).

PROBLEMS WITH THE PRESENT SERVICE SYSTEM

To place matters in perspective, the \$35 million expended annually on services for mentally handicapped Nevadans is producing beneficial results. Although service programs in the state have expanded and improved in recent years, Nevada still has a long way to go to provide all the services that are needed. Major problems still abound, and many people are still receiving no services, the wrong services, or inadequate services.

Given insufficient resources to meet all the needs, compromise and priority-setting are necessary; tradeoffs must be made between the number of people served and the quality of services provided to each of them. Nevada's mental health and mental retardation service system superficially appears to be nearly comprehensive, since it offers programs in most areas of service need. Unfortunately, that appearance is deceptive. Some programs are embryonic; although well intended, they are small and fall far short of filling the needs. Some programs are shallow; although they serve relatively large numbers of people, they are often not providing adequate substantial services to those people.

Later sections of this chapter summarize, for each type of service and for each current program, the many problems Nevada should resolve if it is to improve services for people with mental health disorders, mental retardation, and alcohol and drug abuse problems.

In reviewing the various problems after completing our work, we noted that certain classes of problems occurred again and again among the services and programs: insufficient service capacity in relation to need, inequitable distribution of services by geographic location, lack of coordination and direction of the service system, poor facilities, inadequately trained personnel in some programs and hence poor-quality services, failure to provide a full range of services, absence of a continuum of levels of intensity of service, and failure to have a variety of treatment modalities available to match the variety of people's needs. Finally, too little information is available for program management and for evaluating the effectiveness of programs. Professionals working in the service system in Nevada are well aware of most of these problems, which are not new—nor are they unique to Nevada by any means.

The lack of sufficient service capacity in relation to need is the single most important problem we noted. Still, inadequate service capacity is not the only problem. As we detail later in this chapter, even without major increases in funding levels, some things can be done to improve the services themselves, the organizational structure of the service system, the matching of services with clients, and information on the service programs.

In sum, Nevada's mental health and mental retardation service system is providing needed and beneficial services; with improved organization and support, the system could be far better.

Concerted action on the part of state and local officials is called for if the problems of mental health disorders, mental retardation, and alcohol and drug abuse are to be handled effectively in Nevada. It would be inappropriate for us to try to prescribe that action in detail, but we can provide an action agenda as a starting point. Chapters 3 to 14 of the main text provide the detailed rationale for this agenda, which is summarized below.

SUMMARY AND RECOMMENDATIONS: INDIVIDUAL SERVICE NEEDS

In the following eleven sections we consider the service needs of the individual mentally handicapped person in the following order: direction, prevention, identification, special education and training, mental health treatment, mental retardation services, alcohol and drug abuse treatment, vocational services, medical care, residential living, and income assistance. Whenever appropriate, each section separately discusses and makes recommendations for people with mental health disorders, mental retardation, or alcohol or drug abuse problems. This procedure is essential because there are great differences in the service needs of people with those very dissimilar handicaps, and great differences in the problems associated with current programs intended to meet those needs.

Following the discussion for individual services, we conclude by considering priorities and costs for our recommendations, which are summarized in Table A in the Abstract of this report.

DIRECTION

People who are searching for needed services find a labyrinth of ill-coordinated and highly specialized programs that tax their ingenuity and perseverance in the search. Each current program and its staff usually provide only one or a few specialized services; even if each program and professional does perform well, a single service may meet only a small fraction of the mentally handicapped person's total service requirements. Of course, it is not fair to blame individual professionals for the lack of coordination and direction; they almost never are given the specific responsibility and resources to provide coordination and direction of each client to all needed services. A specially designed direction program is needed for that purpose. For a more detailed discussion of direction and coordination of services than appears below, see Chap. 4 of the main text.

Direction is an information-based service that attempts to match a client's needs with an appropriate mix of available services. It also provides coordination and continuity among the many programs designed to meet those needs. Because a client's needs change over time, the direction concept further requires periodic and systematic reassessment of needs to ensure a "best mix" of services, a mix that is appropriate in amount, quality, and costs of services. The direction service program also could coordinate such important services as prevention and identification, which are not the prime responsibility of any agency in Nevada and are provided unevenly now.

Direction is not well developed in most public service systems in the United States; for mentally handicapped people in Nevada, it is in a primitive state of development. No single identifiable program in Nevada, either public or private, is primarily concerned with direction. In the scattered offices that do provide some direction, it is not the main order of business and is typically provided only on an ad hoc basis. Some slight and incomplete direction service is to be found in the two Special Children's Clinics in the Division of Health, in the two Mental Retardation Interdisciplinary Committees run by the Division of Mental Hygiene and Mental Retardation (only for mentally retarded applicants and clients of the Division's residential treatment programs at the Nevada Mental Health Institute, the two Mental Retardation Centers, and the program of sheltered residential living in developmental homes), and at Nellis Air Force Base (only for military-related people). And, doubtless, some individual public health nurses, social workers, teachers, psychologists, physicians, and others working within the system try to secure a complete range of needed services for individual clients. However, needed services are not always available, as later sections of this report will make abundantly clear. The lack of coordinated services and direction to services that are available remains a major deficiency in Nevada as elsewhere.

In sum, there is almost no comprehensive direction service in Nevada. Information about the overall service system and its components, its clients, its effectiveness, and its deficiencies is simply not available in comprehensive form either to those who need services or to those who are responsible for providing them. In this situation, much of the responsibility for matching an individual's needs with the available services falls by default to the handicapped person or to family and friends. Mentally handicapped people are likely to be poorly equipped for that task, and friends and relatives confront the same lack of information as everyone else. Poor direction and coordination of services have stark implications for the overall operation of the service system. The system should not be expected to work very well when poor direction and coordination exist, and it often does not work well.

Adequate coordination and direction have not been achieved and probably cannot be achieved by relying solely on the individual staff members of various programs. We believe it is better to establish a separate state program responsible for direction and coordination of the service system on behalf of individuals. The information essential for direction and coordination comes from all service programs, and it is more efficient to have that information available and up to date in one place than to try to keep every program up to date on every other program in sufficient detail so that every program could provide a complete and effective direction service. Assigning direction and coordination responsibilities to a separate program staff also would visibly place primary responsibility for direction with that staff, and would eliminate the possibility of having direction and coordination neglected because attention is diverted to meeting other pressing service demands (as can easily happen when a program is primarily responsible for some other service). Another argument in favor of having a separate state direction program is that there are interdependencies among different service programs that may not be adequately taken into account if direction were to be provided by each of those various programs rather than by a separate state-level program. For example, benefits and costs of a service program may be received or borne beyond the bounds of that particular service program; these benefits and costs can be termed "externalities" from the

viewpoint of that particular service program. If direction and coordination of client services by each of these particular service programs is provided by a separate state program, then certain factors that are external from a particular service program's viewpoint can be internal from the viewpoint of the state direction program with its broader perspective.

Furthermore, it is unlikely that anything less than a separate state direction program will achieve the desired coordination of services for individuals, since it is unlikely that other existing state service programs can be effectively coordinated in practice by personnel who are not placed above those programs in the bureaucracy.

We consider the following to be critical requirements for a quality direction and coordination service program, to be administered by the Regional Direction Centers we recommend below. The program should:

- Be a well-publicized point of entry to the service system and a one-stop source of information to match the individual's needs with available services and facilitate access to the most appropriate available services.
- Maintain information about all components of the public and private system, so that individuals can be effectively matched with the most appropriate available services.
- Maintain the information base of the service system on paper rather than merely in people's heads, so that the information is readily transferred when personnel turnover occurs.
- Create a specific and comprehensive service plan for meeting each client's particular needs to the extent feasible with the existing service system, and coordinate with other programs to obtain needed available services for the client.
- Collect and maintain information on each with adequate privacy safeguards, to facilitate planning and delivery of services for the individual.
- Serve as a representative for individual clients in interacting with the service system, to facilitate service delivery.
- Provide for periodic review, through active follow-up, of the appropriateness of the mix of services being provided to each client in light of changing needs and programs.
- Provide a multidisciplinary staff, since people trained in a single discipline generally cannot provide all the expertise needed to plan for the wide range of services needed by mentally handicapped people.
- Provide separate staff expertise for people with needs due to mental health problems, mental retardation, and alcohol or drug abuse problems, since the service needs and programs for serving those groups are significantly different.
- Provide direction and coordination as the primary service of the program, so that attention is not diverted to meeting other pressing service demands.
- Be separate from other major direct service programs in the bureaucracy, so that it is not captured by those programs, and so that too much emphasis is not placed on direction to certain services.
- Be publicly rather than privately provided, since it is unlikely that the private sector could coordinate public sector programs.

RECOMMENDATION 1: Establish two Regional Direction Centers: one in Reno to serve all of northern Nevada, and one in Las Vegas to serve all of southern Nevada,

with separate but cooperating staff for mental health, mental retardation, and alcohol and drug abuse clients. We further recommend that these centers be placed under the operational control of the Nevada Department of Human Resources, and be placed above the administrative level of the various divisions providing the services that the Regional Direction Centers would coordinate. Since not all service programs are within the Department of Human Resources, e.g., education and private service programs, the Direction Centers may need legal authority to coordinate with and exchange information with other public programs, and to provide limited information (with the individual's permission) to private service programs. Privacy safeguards on the information will be essential.

The direction center personnel would not duplicate other services, such as diagnosis, if those services are already provided adequately for an individual in another program such as a mental health center. Initially, the direction center personnel would not have direct authority over other operating program personnel, but would attempt to coordinate services to individuals through persuasion and the exchange of information. Later, if the voluntary approach proves inadequate in Nevada, the direction centers might need to be given greater power. The intent is not to duplicate existing services or dictate to existing programs, but to make them more coordinated, responsive, and effective.¹ While these Regional Direction Centers are highly placed in the bureaucracy, the Centers themselves should be located regionally within Nevada to be near the direct service programs and clients they are supposed to match together. Some mechanism will have to be developed for providing direction to rural clients, perhaps a traveling component of the Las Vegas and Reno Centers.

We recommend starting small, with a staff of perhaps 6 at the Northern Nevada Regional Direction Center and perhaps 12 at the Southern. The operating procedures could be developed, tested, and refined on this small scale with a limited number of clients. If shown to be worth the relatively small cost per client, they could be expanded later.

Offsetting cost reductions and other significant benefits are to be gained if Regional Direction Centers are created. Standardized, accurate, and rapidly accessible management information (necessary for effective and efficient management, but currently not adequately available) could be provided. Additional quality-of-life benefits would accrue to mentally handicapped people and their families from receipt of appropriate services. Dollar-benefits are to be derived from savings in services that people will not need later in life because of more adequate provision of services needed now. Savings in needless rediagnosis and recertification also would be realized by a simple transfer of client records from the direction center to various other servers (although the diagnosis itself might be made originally by some other program, e.g., a mental health center or rehabilitation program). Savings would result from more efficient matching of the needs of a handicapped person with locally available services. The cost per person for a direction and coordination service is not in itself high, and the potential benefits and later savings from that service could be large, but they cannot be accurately estimated using available data.

The Regional Direction Centers would provide coordination for the individual

¹ The Regional Direction Centers we propose are significantly different from the California Regional Mental Retardation Centers (see Chap. 4).

client. Other bodies functioning at the service system level and involved in overall interprogram planning are the Nevada Governor's Mental Hygiene and Mental Retardation Advisory Board, the Nevada Alcohol and Drug Abuse Advisory Board, and the Nevada Developmental Disabilities Council. The essential difference between these bodies' planning and the Regional Direction Centers we propose is that these bodies are primarily concerned with planning for the service system whereas the Regional Direction Centers are primarily concerned with planning for service to particular individuals.

The Governor's Advisory Board presently functions at the Division of Mental Hygiene and Mental Retardation level; its responsibilities include reacting to goals, budgets, and program plans prepared by the division, and acting as a liaison body between the division, the community, and the legislature.²

The Nevada Alcohol and Drug Abuse Advisory Board and the Developmental Disabilities Council presently function at the bureau level within the Nevada Division of Rehabilitation. (Developmentally disabled people include those who are afflicted with mental retardation, cerebral palsy, or epilepsy to the degree that their condition is substantially handicapping and is expected to continue indefinitely.) The responsibilities of the Developmental Disabilities Council include developing a state plan and evaluating programs for the state's developmentally disabled population; it also has a federal- and state-supported budget of about \$111,000 in FY 1975 to support its activities and use in providing grants for projects.³ Like the Governor's Advisory Board, the Developmental Disabilities Council does not presently see preliminary budgets, preliminary goal statements, or preliminary program plans for the various service agencies in the state.⁴ Consequently, the Board and the Council do not have as much input to major service system decisions as they might have.

RECOMMENDATION 2: *Inputs to major service system decisions by the Nevada Governor's Mental Hygiene and Mental Retardation Advisory Board, the Nevada Developmental Disabilities Council, and the Nevada Alcohol and Drug Abuse Advisory Board should be strengthened significantly. To carry out this recommendation effectively, consideration should also be given to having the Developmental Disabilities Council placed in a higher position within the bureaucracy. Since the functions of the two boards and the council are complementary to those of the Regional Direction Centers, and since the centers will have a great deal of information that can be of use to those other bodies, some formal relationship between them could be developed.*

For a more detailed discussion of direction and coordination, see Chap. 4 of the main text.

PREVENTION

Three classes of prevention can be distinguished. Primary prevention denotes

² Interviews with members of the Governor's Mental Hygiene and Mental Retardation Advisory Board, Las Vegas, Nevada, January 6, 1975.

³ Nevada Rehabilitation Division, *Biennial Report*, Department of Human Resources, Carson City, Nevada, 1975.

⁴ Interview with M. Koehn, President, Developmental Disabilities Council, Carson City, Nevada, May 9, 1974.

activities performed for the entire population at large, not specifically the handicapped population; secondary prevention is done for the limited population of identified high-risk groups of people who are vulnerable to developing mental disorders; and tertiary prevention includes all treatment and rehabilitation of handicapped people. Prevention of mental disorders is so self-evidently a "good" objective that no one can dispute its usefulness or desirability, but only its costs, methods, and feasibility.

Prevention is far harder to practice than to preach, however. Nevada's programs for the prevention of mental disorders are in an embryonic, underdeveloped stage, but the state is not alone in that regard.

Current expenditures in Nevada for the prevention of mental handicaps are impossible to estimate accurately; so is the number of handicaps prevented. Some very small but inestimable fraction of programs to improve societal-environmental living conditions for the general population can be considered as going for primary prevention of mental handicaps. More directly, some small fraction of expenditures for maternal and infant care, counseling, family planning, nutrition, immunizations, Medicaid, and other programs contribute partly to the prevention of mental handicaps, but we have no meaningful way of estimating that fraction with available data. The only expenditures we identified that we could specifically attribute to the primary and secondary prevention of mental handicaps were: alcohol and drug abuse education, about \$300,000 a year; genetic testing and counseling for mental retardation, about \$75,000; and less than \$50,000 for Crisis Call and Suicide Prevention telephone programs. For a more detailed discussion of prevention of mental disorders than appears below, and for citations of the literature on prevention, refer to Chap. 5 of the main text.

Prevention of Mental Health Disorders

So little is known about the specific causes and prevention of mental health disorders that preventive measures lack precision and it is difficult to evaluate their effects. Prevention of mental illness is not a new idea, but it is seldom made into an operational program. How does one "prevent" disorders whose causes are so poorly understood?

Genetic control programs are of no significance in practice today. In the absence of etiologic data, genetic counseling for mental health problems has yet to pass from the realm of academic inquiry into application. Providing a stable and stimulating living environment is a preventive "good," but then so are many similar activities. Teaching people how to know themselves, to perceive and understand reality, to make realistic plans, to relate to others, to care and be cared for, to accept and deal with change, to accept responsibilities, and to practice effective birth control are all potential preventive approaches. For all of these approaches there exist related intervention practices, but for all of them—approaches and practices alike—the preventive aspect of reducing mental health disorder is still open to question. There is less doubt about the need to increase public awareness of mental health problems, but even here there are few clear prescriptions, many all-too-clear problems, and not many notable successes.

Society is somewhat better equipped to provide secondary prevention to help "identified vulnerable, high-risk groups," but there are problems here, too. A person with a high risk of developing a mental disorder is too seldom in touch with skilled

mental health providers to be identified early, so that secondary preventive measures can be taken. More often than not the disorder develops and advances over an extended period of time. Ultimately, if fortunate, the person is taken on by a competent psychologist or psychiatrist, by which time the object is treatment, not prevention. Procedures should be designed to make the mental health service system and its prospective clients more readily accessible to each other.

Characteristic practices identified as secondary prevention include counseling for people who are grappling with one of life's many crises, such as the death of a family member, serious illness, handicaps, accidents, and economic deprivation; helping people resolve problems of interpersonal relations; and identifying "developmental" and "situational" conflicts early enough that appropriate treatment can be pursued (the distinction between *treatment* and *prevention* blurs at this point).

Faced with so many possible secondary prevention practices, the problem from a policymaker's viewpoint is exceedingly complex. Which practices are the most effective? Which ones work at all? The lack of data poses fundamental and unresolved difficulties. All that can be said responsibly is that any or all of these practices may reduce the incidence and prevalence of mental health disorders.

Allocating scarce resources, the practical matter at hand, involves setting priorities. In light of the rudimentary state of knowledge about the primary and secondary prevention of mental health disorders, we believe there are more demonstrably effective ways for Nevada to spend money than on additional primary and secondary prevention, important though that is. Consequently, we make no recommendations for additional expenditures in this area. However, we do note that some of our recommendations later in this report, such as those for improving the identification of people with mental health disorders and for improving the service capability of the mental health service system, will enhance early treatment of mental health disorders and hence improve tertiary prevention.

Prevention of Mental Retardation

There are more than 200 identified specific causes of mental retardation, including metabolic errors, genetic anomalies, drug abuse, environmental pollution, radiation of pregnant women, infections, accidents, and improper nutrition. Societal conditions affecting behavioral adaptation are also related to mental retardation, but the data are poor on the nature and extent of the relationships.

Many types of mental retardation can be prevented, including several of the more prevalent types. Reliable genetic information for a host of retardation-causing disorders can be provided to parents and prospective parents (e.g., those most likely to have abnormal children) but social, emotional, and moral problems are associated with this procedure. For example, society knows how to detect Down's Syndrome (mongolism) in the unborn fetus, but prevention at the fetal stage depends on family decisions regarding therapeutic abortion. Immunization can prevent infectious diseases that cause retardation, but many children are not immunized. Although very low in prevalence, retardation caused by PKU (phenylketonuria) is largely preventable through dietary means in children whose disorder is diagnosed early enough. Development and use of the Rh desensitizing gamma globulin for mothers has reduced jaundice in the newborn and thus has also reduced incidence of the associated mental disorder, kernicterus.

Nevada offers direct service programs for people who are already mentally retarded. Those programs can be called tertiary prevention programs in the sense that they work to help mentally retarded people to alleviate or eliminate their functional retardation. Nevada has only a few programs for the secondary prevention of mental retardation, however, and they are uncoordinated, highly undeveloped, and, as a consequence, not available to all Nevadans in need.

RECOMMENDATION 3: *Expand genetic testing and counseling capabilities, and create a high-risk registry for parents and potential parents of mentally retarded children.* We stress that genetic testing and counseling would be provided on a voluntary basis; the intention is not to tell families what to do, or to offer value judgments on a family's decisions, but to provide them with information they can use in arriving at their own decisions to conceive and bear children. The Special Children's Clinics provide a limited amount of this service now. The expansion we are recommending is to have a full-time genetic testing and counseling team in northern Nevada, and another in southern Nevada. Those two teams could also travel to rural areas part-time to provide service. The creation of a high-risk registry (with information and direction-like referral built in) would help make genetic counseling available to those most likely to benefit from it. The registry could include, among others, pregnant women over 35 and under 17, and families with a history of a retardation-causing metabolic disorder or an inherited genetic disorder capable of causing mental retardation. The various medical, mental retardation, and special education programs in the state would serve as sources of referrals.

RECOMMENDATION 4: *Implement monitoring and enforcement mechanisms to help ensure that all children of early school-age are immunized against potentially handicapping infectious diseases, that all newborn children are screened for PKU, and that Rh desensitization is provided when needed.* PKU screening, Rh desensitization, and immunization for measles and rubella are effective and economically justifiable in helping prevent mental retardation and other handicapping conditions. (See Chap. 5 of the main text for details.) In accord with Nevada law, PKU screening is supposed to occur routinely for newborns. These preventive services are relatively well provided in Nevada, but mechanisms are needed to ensure that coverage of the subject populations is as nearly universal as possible.

RECOMMENDATION 5: *Soon after the birth of a child, provide family planning information to the parents, and create a registry and provide follow-up for children born abnormal or at high risk of being mentally retarded or having some other handicap.* Family planning practices are related to the likelihood of having a mentally retarded child. The registry and follow-up for high-risk children would be especially valuable in permitting early detection of retardation or other handicaps, so that preschool special education and training and other services (tertiary prevention) could begin at an early age. The Southern Nevada Special Children's Clinic has a pilot project underway to develop a registry and follow-up for children born abnormal or at high risk.

Good prenatal and perinatal medical care is an important factor in preventing retardation. The main question is how to secure such care for pregnant women and new mothers if they are not receiving it. One can envision increased outreach by public health nurses and others to women who are not likely to seek good prenatal health care, and to women who do not return for routine and periodic checkups of their babies. Perhaps the largest improvement, however, would come from lowering

financial barriers to good medical care. The state, for example, might consider requiring that private insurance carriers cover prenatal and perinatal care fully, without deductibles, including coverage of the child from the moment of birth.

RECOMMENDATION 6: *Establish specific responsibility for mental retardation preventive services within the Department of Human Resources (perhaps in combination with the new unit for direction services recommended earlier).* We are not saying that these personnel who are assigned overall responsibility for prevention should operate all prevention programs, since some functions reside appropriately elsewhere in state government. Rather, we are saying that preventive efforts need to be coordinated, and someone needs to take responsibility for guiding the building of a high-quality system of preventive services in Nevada. Placing this responsibility at the state level would help ensure that at least a minimum level of preventive services is provided in each geographic area of the state.

Prevention of Alcohol and Drug Abuse

Unlike many mental health problems, alcohol and drug abuse often involves acts of choice, at least insofar as a person decides to drink or use drugs in the first place and often decides when and how often to do so. For this reason prevention programs may well have important long-term consequences in reducing and controlling alcohol and drug abuse.

At the present time, however, there has not been a major investment in prevention programs at federal, state, and local levels; the great bulk of funds has been invested in direct provision of treatment services to alcoholics and drug addicts. Nevada is no exception. Aside from some educational programs for schoolchildren, there is very little prevention in Nevada; some TV spots have been prepared by various groups, but there is no really major "public education" campaign in progress. In total, we estimate that the annual alcohol and drug abuse prevention expenditures by all sources in Nevada are on the order of \$300,000 to \$400,000, with a full-time-equivalent staff of no more than five people.

Preventive measures have not proved to be especially effective, with the possible exception of the strict supervision and regulation of the production of drugs and alcohol, which cannot be done effectively at the state or local level. Alcoholism is similarly resistant to prevention. Prohibition, a thirteen-year "social experiment" in prevention and social control, was a failure. Some deterrent effect of unknown extent is probably achieved, however, through high liquor taxes, prohibition of sales to minors, and restrictions on locations and times of sale, all of which at least reduce drinking opportunities. Treatment and public education undoubtedly reduce the problem to some extent, but no conclusive work has been done to establish the relative merits and effectiveness of the few preventive options available.

Unfortunately, no one can say with certainty what kinds of alcohol and drug abuse prevention programs are effective and should be promoted. The volitional element in alcohol and drug abuse, which makes prevention theoretically attractive, affords a ray of optimism in this otherwise murky picture. But until better information is available on the effectiveness of alcohol and drug abuse prevention programs, we cannot recommend any major expansion in the current prevention program in Nevada.

For a more detailed discussion of prevention programs, see Chap. 5 of the main text.

IDENTIFICATION

Identification, in the context of this study, is the recognition and accurate assessment of a person's disabilities and abilities. Four observations were corroborated again and again in our interviews with agencies and in our investigations of data on services provided: (1) agencies usually do not serve a significant portion of the population in need; (2) agencies generally do not even know approximately how many unserved people there are, much less who they are; (3) very few agencies have effective outreach or screening programs to identify the population in need; and (4) referral and follow-up for those who are identified are often lacking.

All of Nevada's efforts to screen for potential mental handicaps prior to full diagnosis, and to reach out to find potential clients for service programs cost perhaps \$200,000 to \$250,000 in FY 1974. These cost figures do not include the cost of diagnosis following screening, nor do they include the cost of personnel who notice a possible mental disorder while they are primarily involved in providing some other service (e.g., education, medical, or social welfare services). The primary screening and outreach efforts were the early screening program for Medicaid-eligible children; a school screening program for all children in one rural county (the two counties with large populations, Clark and Washoe, do not screen all schoolchildren for mental handicaps); an outreach program of the two state Special Children's Clinics; and small, still rudimentary outreach programs at the Reno and Las Vegas Mental Health Centers. For a more detailed discussion and analysis of identification services than appears in this section, refer to Chap. 6 of the main text.

In general terms, people who have mental health disorders, mental retardation, or alcohol or drug abuse problems, currently become identified to the service system primarily through either of two mechanisms: (1) personnel in some segment of the service system (e.g., police, private physicians, and teachers) have "trouble" with an individual, or notice symptoms of a disorder, or (2) the individual or his or her family seeks assistance. Even after a mentally handicapped person is identified by one part of the service system, the mechanism of making referrals to all other appropriate service programs is often not used; therefore, the person is often unidentified to, and unserved by, some or all of those other programs. Regional Direction Centers would help resolve this latter problem.

There are several plausible reasons for the current weakness of identification as a service. In noting what appears to be the main reason in Nevada, our intent is not to excuse the current situation but to lay out the underlying rationales that must be understood in order to effect remedial courses. In interviews with service providers, we were repeatedly told that the paucity of available services discourages identification and referral initiatives; if the service system is already overburdened, it is logical to ask why one should bother hunting for still more clients. There are three answers to that question:

- Not all of those with the greatest need or the greatest ability to benefit from services are among those known to the service system. Since service needs exceed service capacity in most areas, each program could set priorities and use its limited resources accordingly. However, even if they have defined high-priority types of clients, they cannot be serving as many of the high-priority clients as they might serve, since not all those high-priority clients have been individually identified.

- Were more of those in actual need identified, then the service system might eventually decide to respond with a more adequate level of services. If a clear picture is lacking of the overall population's needs, including the names of people needing service, it is unlikely that sufficient service system capacity and a range of adequate services to meet these needs will be provided; that situation currently prevails in Nevada.
- People in need can benefit from knowledge of the nature of their condition, even if we assume that the public sector cannot serve them or chooses not to. With accurate and reliable information about the basic condition and services required, people with mental problems and their families are somewhat better prepared to help themselves and to seek out private sources for service.

The following recommendations are aimed at the problems noted above.

Certain of the ideas developed above on prevention are relevant to identification. In particular, recall our earlier recommendations for creation of a registry and follow-up of children born abnormal or at high risk of being mentally retarded or having some other handicap. Reporting to the registry by medical personnel could be mandatory. The registry and follow-up for high-risk children would be especially valuable in permitting early detection of retardation or other handicaps, so that preschool special education and training and other services could begin at as early an age as is desirable.

RECOMMENDATION 7: *Require parents of children beginning their first year of school, or entering a Nevada school for the first time from out of state, to present to the school as a condition of admission of the child either (1) the results of an approved health and developmental screening by an approved professional, or (2) a statement that the parents have decided not to have their child receive the screening services.* There is no formal mechanism to screen and identify children, a key target population for any physical health, mental health, or mental retardation service system, after they leave the newborn nursery and until they enter elementary school. In this case we are speaking of a medical examination designed to detect a range of potentially debilitating mental and physical conditions so that services may be offered at as early an age as is desirable to help alleviate the effects of the mental or physical disorder. This screening is valuable but not infallible for two primary reasons: parents may choose not to have their children screened for various reasons; and the screening methods for the detection of mental disorders at the age of 4 or 5 years are not as valid and reliable as we would like them to be. Nonetheless, most of the more severely disordered children can be detected with existing screening methods. Care must be taken, however, not to label children for whom the results of the screening and later diagnosis are not clear-cut. Before implementing this recommendation, the screening mechanisms to be used would have to be carefully considered. If these recommendations were adopted, the Medicaid Early and Periodic Screening, Diagnosis, and Treatment program would pay for the screening for Medicaid-eligible children. The results of the screening would be forwarded to the state (to a Regional Direction Center, ideally), where they could be used to follow up to see that the various appropriate mental health and mental retardation programs provide needed service at as early an age as is desirable, and to aid in planning future service programs. Implementation of privacy safeguards for people identified will be essential. Churchill County already has a commendable screening program

provided by both medical and school district personnel for every child entering the school system. California has recently implemented a related program (see Chap. 6 of the main text for descriptions of those different but related programs).

RECOMMENDATION 8: *Adopt procedures to help ensure that (1) all Medicaid-eligible children and youth up to age 21 years receive early and periodic screening, unless such screening is formally refused, and (2) follow-up steps are taken to obtain diagnosis and treatment for those who need them.* Nevada has implemented the federally required Medicaid Early and Periodic Screening, Diagnosis, and Treatment program, but the program as implemented does not check to see that all Medicaid-eligible children are screened, and does not always adequately follow up on the results of the screening. The Regional Direction Centers (if created) would be useful in making referrals and coordinating needed services and follow-up. We note that implementation of this Medicaid screening would facilitate not only the provision of needed services, but also the transfer of eligible clients from the Aid to Dependent Children program to the more desirable Supplemental Security Income program (see the "Income Assistance" section of this report for details).

RECOMMENDATION 9: *Provide increased funding for the two existing Special Children's Clinics, distributed between the two clinics more equitably on a per capita basis than it is now, including stable funding of a traveling multidisciplinary team to perform diagnoses in rural areas for people of any age thought to be potentially mentally retarded.* This would provide improved diagnostic services for mentally retarded people. We note that some rural counties do not even have a school psychologist who could help with diagnoses.

RECOMMENDATION 10: *Establish a screening program in every county school district to identify all mentally retarded and seriously emotionally disturbed children who need special education and other services.* A school district cannot adequately serve children with mental handicaps and refer them for other services if it does not know who they are. The schools are an ideal setting for identification of mental handicaps in young people of school age, since nearly all children are assembled, observed, and compared on a routine basis. Since screening of schoolchildren is feasible and not excessively costly, and the human and economic costs can be great if young handicapped people do not receive timely special services, all children should be entitled to at least one behavioral and psychological screening to detect possible mental retardation or serious emotional disturbance. Nevada lacks such a program. School psychologists in most counties do not screen all children; and since there are many unidentified mentally handicapped children in school, the mechanism of relying solely on teacher referrals has not been very effective. We earlier suggested that a medical and developmental screening program reach children before they first enter school. Here we are recommending that the schools conduct a different behavioral and psychological screening of all children when they reach a specified age (perhaps 7 or 8 or 9 years old) to identify any who were missed in the preschool medical and developmental screening or whose mental health or mental retardation problems developed or became identifiable in the years since the preschool screening.

RECOMMENDATION 11: *Screen high-risk populations to identify people who might be offered immediate mental health and other needed services to help alleviate existing mental health disorders before the subjects become more seriously ill or dysfunctional.* While a mechanism does not exist to readily reach everyone in high-

risk populations, many can be reached by the mechanism of screening people who are in contact with public service systems for other reasons. For example, likely candidates for screening would be abused children and their abusers who come to the attention of health, welfare, and criminal justice personnel, juvenile and adult offenders, residents in the two Nevada Children's Homes, emotionally disturbed schoolchildren, children of a psychotic parent who is in contact with the mental health service system, and some callers to Crisis Call and Suicide Prevention lines.

For a more detailed discussion of identification, see Chap. 6 of the main text.

SPECIAL EDUCATION AND TRAINING SERVICES

Nevada law requires special education of all handicapped minors of particular ages. We are primarily concerned here with special education services for seriously emotionally disturbed children and youth to age 18 years, and special education and developmental training of mentally retarded people. While highly important, the special needs of children the education agencies term "learning disabled" are not within the central scope of this report if they are not primarily mentally retarded or seriously emotionally disturbed. However, we present data on the special education programs' services to children the education agencies term "educationally handicapped," since children who are primarily emotionally disturbed, mentally retarded, or learning disabled are sometimes served together in Nevada under the label of "educationally handicapped," and since many children can be classed as either or both emotionally disturbed and learning disabled under the rather vague definitions of those terms (see Chap. 7 of the main text for a detailed discussion of those definitions).

The major special education and training programs serving mentally handicapped Nevadans spent more than \$9 million for them in FY 1974; those programs are operated in two state departments, in county school districts, and in the private sector. The county school district special education programs provide the vast majority of all special education and training services, and operate under standards of the Nevada Department of Education with partial state funding; the Community Training Centers program consists of six very small private centers operating under guidelines and partial funding from the Nevada Division of Mental Hygiene and Mental Retardation; the Special Children's Clinics operated by the Nevada Division of Health have two small preschools and infant stimulation programs (the one in Reno is a cooperative program with the Washoe County School District); and the Washoe County School District operates a special education and training program at the Nevada Mental Health Institute for retarded youth. In addition, a small federally funded program, P.L. 89-313, provides special education personnel at some state facilities (see Chap. 10 of the main text for a description).

Of the more than 3700 mentally or educationally impaired children receiving special education in FY 1974, only about 100 emotionally disturbed children are identified as being served in Clark, Churchill, and Washoe Counties combined. No seriously emotionally disturbed child is known to be receiving any appropriate special education service in any of the other counties in Nevada. About 1644 mentally retarded children and youth received special education in FY 1974. Over half of the possibly mentally impaired children served are not identified as either men-

tally retarded or as seriously emotionally disturbed; nearly 2000 "educationally handicapped" children received special education in FY 1974. The characteristic most often possessed in common by educationally handicapped children is low academic achievement, and some of these children undoubtedly are mentally retarded or seriously emotionally disturbed, or both. Even so, the total number of children served with all types of mental and "educational" handicaps combined is far below the minimum estimate of the total number of seriously emotionally disturbed and mentally retarded children needing those services. Nevada is below the national average in terms of the number of seriously emotionally disturbed and mentally retarded children in special education in relation to total school enrollment, and even the national average leaves much to be desired. Despite the state law requiring special education of all handicapped minors, we estimate that in relation to the minimum number of Nevadans needing special education and training services, only about 4 percent of seriously emotionally disturbed children are identified as such and served, and only about 54 percent of mentally retarded children and youth are served. Even if one assumes that every educationally handicapped child served is either mentally retarded or seriously emotionally disturbed (which is certainly not true), only about 63 percent of those in need are being served.

Although Nevada's special education and training programs are improving, several problems with those services for mentally handicapped children and youth can be identified. They include insufficient funding and service (less than half of those conservatively estimated to be in need are served); inequities in service by type of mental handicap (services specifically for seriously emotionally disturbed children are nonexistent in most Nevada counties and are provided to a token number in a very few other counties); a questionable allocation of about half of the limited special education resources available for serving mentally handicapped people to people with the generally less severe "educational handicaps"; differential service by sex (boys outnumber girls in special education in Nevada two to one, and we seriously question whether there are twice as many handicapped boys as handicapped girls in the general Nevada population); and inequities in service by geography (for all handicapped children in the remoter rural areas of every county, and for trainable and more severely mentally retarded children in the entirety of all but a few counties). Those problems also include insufficient attention to the transition from school to adult services (e.g., to the vocational rehabilitation program if those services are needed); lack of programs in schools for comprehensive identification of all mentally handicapped children needing services (none of the three largest school districts, which contain three-quarters of the state's school-age population, has a screening program reaching all children); lack of direction to other service providers; and lack of information (at the state level, even the number of mentally handicapped children in special education is not accurately known, and quantitative data on the effectiveness of Nevada's special education are virtually nonexistent). Finally, there is a problem of an inadequate number of professional staff to manage the special education program at the state level (only two consultants), and of triplication of preschool education responsibility at the state level (among the Department of Education, the Division of Health, and the Division of Mental Hygiene and Mental Retardation). Of all the problems listed, the greatest by far is the large fraction of seriously emotionally disturbed and mentally retarded children who receive no special education at all.

The primary concern, then, is to expand special education services and make them available to all seriously emotionally disturbed and all mentally retarded children and youth who need them, as is required by law. In our view, the two factors most responsible for restricting the number of mentally handicapped children receiving special education are: (1) the limited number of units (basically, special education professionals) for which the state will provide financial support, and (2) the lack of identification programs for mentally handicapped children in the county school districts. Obviously, a school district cannot serve mentally handicapped children if it does not know who they are. To help remedy this lack of knowledge, we earlier recommended that a screening program be implemented in each school district.

RECOMMENDATION 12: *Provide state financing for an additional 230 special education units above FY 1974 levels specifically for seriously emotionally disturbed children, and an additional 163 units above FY 1974 levels specifically for mentally retarded children. This would furnish special education to a total of 2880 seriously emotionally disturbed children and 3090 mentally retarded children, the minimum number we estimate need such services. If more than those minimum numbers of handicapped children are identified by the screening program we have recommended, the number of special education units can be adjusted accordingly. The Nevada Legislature has been ambivalent by mandating special education for all handicapped children but failing to allocate funds to cover the expense. The legislature did significantly increase the number of units in 1975, however, and thus continued the growth of the special education system. Since special education of all handicapped children is legally required in Nevada, we suggest a state goal of having every handicapped child in special education by 1980. (A lawsuit also has been filed in Nevada to force the provision of special education to all handicapped children; this is essentially the same lawsuit that has been won in other states on constitutional grounds.) While spreading the action over a five-year period does not solve the problem of unmet needs immediately, it will allow time to identify the children in need, to modify facilities and retrain personnel, and to hire high-quality new special education teachers. Cost estimates for implementing this and other special education and training recommendations are developed in Chap. 7 of the main text.*

RECOMMENDATION 13: *Make the definitions of handicapping conditions issued by the Nevada Department of Education more specific, place limits on the number of units by type of handicap, including seriously emotionally disturbed children as a separate category, and enforce all special education standards. Inequities in service by type of handicap may be only partially resolved by increasing the number of units funded. Under current definitions used in Nevada education, children with significantly different service needs are lumped together under the term "educationally handicapped." The term is so broad that large numbers of children could find themselves labeled unnecessarily, and many children who do not have substantial handicaps (e.g., children who need only remedial reading) might be placed in special education, while those with substantial handicaps might go unidentified and unserved if funds are not earmarked for them.*

RECOMMENDATION 14: *Significantly increase the special education staff of the Nevada Department of Education to at least 10 full-time-equivalent professional staff members so that they can provide guidance and consultative technical assistance to rural county school districts, and so that they can more adequately manage their*

major responsibilities in the area of special education. The two consultants who currently make up the state special education professional staff are to be commended for the fine job they are performing, but they are only human; a much larger staff is needed. Since it is not reasonable to expect the rural school districts to have, on their full-time county staffs, all of the specialized and expensive special education expertise they may need, the Nevada Department of Education should provide for consultation and technical assistance to rural special educators.

RECOMMENDATION 15: *Provide nearly all mentally retarded Nevada Mental Health Institute residents with special education and training services appropriate to their level of development; provide those special education and training services away from the institutional setting for nearly all residents; and provide a teaching aide and adequate equipment and materials for each special teacher. The present numbers of teachers, aides, equipment, and materials are inadequate in relation to the clear need. Service away from the institutional setting would enhance the education, training, and quality of life of residents by giving them wider exposure to the normal situations and experiences of everyday life.*

RECOMMENDATION 16: *Focus the preschool portion of the Community Training Center (CTC) program in rural areas on developmental stimulation and training for the more severely retarded children below age 3 only. In the Las Vegas and Reno areas, have the CTCs serve only adults, leaving developmental stimulation and training for the more severely retarded children below age 3 to the Special Children's Clinics. The CTC program as presently operated is a dichotomous entity that provides two basically different kinds of service to mentally retarded people: a preschool program, and a program of day-care, activities of daily living, prevocational, and vocational (including sheltered work) services for the more severely mentally retarded people about age 18 or above. This recommendation for a change in CTC focus arose primarily because the age range for mandatory special education of mentally retarded children by the public school system was lowered by the Nevada Legislature to age 3 in 1975. These changes in focus will decrease the present fragmentation and triplication of responsibility for preschool special education and training programs. Also see recommendation 54, which concerns the funding of Community Training Centers.*

RECOMMENDATION 17: *Have the Special Children's Clinics program transfer their 3- and 4-year-old nursery-school children to the county school districts and concentrate its very limited resources on identification of preschool-age retarded children, direction of their families to other service providers, counseling of families with retarded children, and developmental stimulation and training for the more severely mentally retarded children below age 3. The Nevada Division of Health's Special Children's Clinics program presently operates two small nursery schools and infant stimulation programs, primarily for preschool mentally retarded children who were not served by the county school districts in FY 1974. This recommendation is made possible by 1975 legislation which requires the special education by public schools of 3- and 4-year-old mentally retarded children.*

RECOMMENDATION 18: *Improve referral from special education to other programs serving mentally handicapped children and youth. In particular, increase the number of referrals to Vocational Rehabilitation of mentally handicapped youth well before they leave school, and increase the number of referrals of seriously emotionally disturbed youth (whether or not they are in special education) to the local*

mental health center or rural mental health clinic, or Children's Behavioral Services program. The schools are not designed to provide every type of service well, nor should they be, since other programs exist to provide those services. These referrals could all be made and followed up by Direction Centers, if they are created. In the event that other programs do not have adequate resources to serve all those in need of service, then priorities should be established and all referred youth should be screened so that high-priority needs are met first.

RECOMMENDATION 19: *Obtain improved program management and effectiveness information for each Nevada special education and training program. Available information on special education and training in Nevada is inadequate for effective program management, accountability, evaluation, and planning (recall that we are not even sure exactly how many mentally handicapped children are in special education).*

For a more detailed discussion of special education and training services and cost estimates for the above recommendations, see Chap. 7 of the main text.

MENTAL HEALTH SERVICES

Nonresidential Mental Health Services

Nonresidential mental health services include outpatient, emergency care, and day treatment psychological services. They are delivered in Nevada primarily through Mental Health Centers, Children's Behavioral Services programs, Rural Clinics, Suicide Prevention and Crisis Call lines, by psychological counselors in schools, by the military, and by psychiatrists and psychologists in private practice. Residential treatment services for mental health disorders, and all services by the Nevada Mental Health Institute, are discussed in the next subsection. For a more detailed discussion and analysis of these programs than appears in this summary, see Chap. 8 of the main text. Desirable features of a psychological service system are described in some detail in a separate section of that chapter. Basically, we take the eclectic position that people experience a variety of kinds of mental health problems, which should be dealt with by a variety of kinds of professionals and paraprofessionals in the least restrictive environment possible, employing a variety of approaches and treatment modalities as appropriate to the particular individual's problems. Our orientation is that no one single modality or approach is the best for every client, and hence no one (such as drug therapy or behavior modification) should be used almost exclusively by a mental health service agency.

We have estimated that, as of 1975, at least 11,000 Nevadans have significant mental health disorders that result in a substantial need for psychological or psychiatric services. That figure is a conservative minimum estimate; the true figure may be as much as five times that, or 55,000 people. The two predominant segments of the nonresidential mental health service system currently intended to meet those needs are the private psychiatrists and psychologists, and the Nevada Division of Mental Hygiene and Mental Retardation. Of the estimated \$3.3 million in public and private funds spent in FY 1974 for nonresidential mental health services in Nevada, the Nevada Division of Mental Hygiene and Mental Retardation accounted for about 51 percent, private psychiatrists and psychologists accounted for about 42

percent, and the remaining 8 percent was provided through various other agencies. A total staff of about 171 people provided services in person to a maximum caseload of about 10,500; another approximately 6800 callers to Suicide Prevention and Crisis Call Centers were served by telephone. To some degree, however, these numbers represent apparent rather than actual service achievements for the mental health service system. For reasons given immediately below, the number of *different people with mental health disorders* served in person in FY 1974 is significantly less than 10,500; one cannot conclude that nearly all 11,000 people needing substantial psychological or psychiatric services (our minimum estimate) are being served. The 10,500 figure is a count of the number of cases served by the various agencies, and includes: double-counting if people were served by more than one agency in a year or were admitted to the same agency's program more than once; counting of people served who do not have substantial mental health disorders (e.g., some parent-effectiveness trainees in the Children's Behavioral Services program, some consciousness-raising group participants at the University of Nevada, some mildly neurotic people served by private professionals, and various types of people served by Rural Clinics, such as those receiving premarital counseling); and counting of people who are not really served (e.g., those who are counted as cases but who do not return after an initial intake interview—33 percent of outpatient cases at the Las Vegas Mental Health Center were of this type). Finally, cases reported by the agencies may represent people served who have substantial mental health disorders, but who were inappropriately served because of the nonexistence of a service they needed, such as day treatment, or inadequately served by a relatively unskilled and untrained mental health technician.

We could not accurately determine what fraction of the 10,500 cases reported as served by the programs represented different people with substantial mental health disorders who were adequately served, so we have reported the maximum 10,500 figure and caution the reader as to its meaning.

In two of the recommendations in this section we urge specific Nevada programs to increase the emphasis on service to people with the more severe mental health disorders. This means a shift in emphasis for those specified programs and should not be interpreted to mean that only severely mentally handicapped people should be served. There also is a clear and important need to serve people with less severe mental health disorders when effective treatment methods are available. Several of our recommendations are specifically aimed at improving services to less severely handicapped people.

There is a major difference in the total amount of nonresidential mental health service delivery per capita by geographic region: rural counties have a combined public and private caseload of about 11 per 1000 population, Clark County has about 17 per 1000, and Washoe County has about 26 per 1000. The relatively underserved rural area of the state receives almost no services from private psychiatrists and psychologists; most of the service that is provided comes from the state Rural Clinics mental health program, which has a seriously deficient staff. Clark County is better served on a cases-per-capita basis, and Washoe County is by far the best of the three areas on that same measure. However, that measure does not reveal the fact that in Washoe County the mental health center provides only a limited range of services that are not appropriate for all persons' needs; it does not provide a needed day treatment program or 24-hours-a-day emergency care, for example. This major

difference in the level of service per capita in different geographic regions also exists in the public service system considered by itself, despite the fact that the public service system is state operated.

The problems we note with respect to nonresidential mental health service include: insufficient service capacity to meet the minimum need in each area of the state, with the greatest deficiency being in rural counties; mental health technicians inadequately trained and supervised in relation to their mental health treatment responsibilities; lack of a continuum of levels of nonresidential services in each area; excessive reliance on a single treatment modality in some programs in 1974; inadequate follow-up service to people released from the Nevada Mental Health Institute; few services to emotionally disturbed children in the schools; and almost no mental health services for mentally retarded people.

RECOMMENDATION 20: *Fill all authorized professional staff positions at the Las Vegas Mental Health Center.* A number of problems noted with both residential and nonresidential services at the center in 1974 (problems with intake assessment, staff supervision, and smooth transition from one level of care to another) could be resolved if the center had all authorized professional staff positions filled. The administrator of the Las Vegas Mental Health Center indicates that as of February 1976, the "vast majority" of these professional positions are filled. The one major problem that cannot be resolved by filling those professional positions is the lack of training and skills of the mental health technicians; a subsequent recommendation will deal with this problem for mental health technicians in all programs.

RECOMMENDATION 21: *Provide 24-hours-a-day emergency crisis intervention service in every mental health center and in the Rural Clinics mental health program.* While it is obvious that people with mental health disorders require emergency help at times other than weekdays from 8 a.m. to 5 p.m., some of Nevada's major current mental health programs do not have 24-hours-a-day emergency crisis intervention service. This emergency service should include an in-person crisis clinic plus the ability to provide emergency care on an overnight basis if needed, so as to provide needed service and also help avoid unnecessary hospitalization. For details see the section of Chap. 8 of the main text entitled, "Desirable Features of a Psychological Service System." We assume that staff members on duty evenings, nights, and weekends would provide more than just emergency services, to the extent possible, so they are efficiently utilized. For example, emergency services can now be provided by non-weekday staff on the residential service units of the Las Vegas Mental Health Center.

RECOMMENDATION 22: *Substantially increase (at least double) the staff of the Rural Clinics mental health program; have a full range of professional skills represented on the staff so that a full range of treatment modalities can be used; substantially upgrade the skills levels required of mental health technicians as described in a subsequent recommendation; continue in operation the present offices in rural areas; and provide for visitation of each rural office one day a week by a traveling multidisciplinary team of senior mental health professionals to supplement the lower-skilled rural office staff.* Nonresidential mental health services to rural Nevadans are substantially worse, in both quantity per capita and quality, than those available in Las Vegas and Reno. Because it is probably not feasible to staff each rural office with a full team of professionals, we suggest a set of two traveling teams, each on the rural office circuit about half the time. Thus, skills such as those of a psychiatrist, which are needed for chemotherapy and other modes of treatment

but are not needed full time, would be available in each rural area. Local rural office staff would provide outpatient follow-up and emergency services. Traveling teams would complement and supervise the local office staff, assist on difficult cases, and help to follow up discharged residential patients. Residential mental health services needed by rural residents would be provided by the Nevada Mental Health Institute, probably by the same personnel who make up the two half-time traveling teams. Thus, two full-time teams could serve rural residents; each would work half-time with patients from rural areas at the NMHI while the other was visiting Rural Clinics offices.

RECOMMENDATION 23: *Increase the Rural Clinics efforts on what appears to be the greatest need, service to people with substantial mental health disorders.* The current Rural Clinics personnel are spreading themselves thin trying to do many different things and are not adequately serving most people with substantial mental health disorders. Rural Clinics is an excellent example of a small, embryonic program with admirable goals that exists mainly on paper as far as many rural Nevadans, especially those with the more severe disorders, are concerned.

RECOMMENDATION 24: *Establish a second community mental health center (CMHC) in Clark County.* The present Las Vegas Mental Health Center is operating at nearly full capacity and there are still clear unmet needs in the county, e.g., in the areas of follow-up of released residential service patients, service to emotionally disturbed children and adolescents, service to rural residents of Clark County, and service to mentally retarded people with mental health problems. The main problem with the existing Henderson Mental Health Center is that it is extremely small in relation to the two-thirds of the Clark County population in the geographic catchment area it is supposed to be serving. The small Henderson Mental Health Center does not provide a full range of services and is not located near the center of the population it is supposed to serve. We suggest the present Henderson Mental Health Center be retained as a satellite office of a new community mental health center designed on the order of the present Las Vegas Mental Health Center and located on the opposite side of Las Vegas. Population growth in Clark County that will occur before a new CMHC could be operational adds further weight to arguments favoring a new CMHC. No one really knows for sure how many people need mental health services in any of the three major areas of the state, but the existing pressure on the service system in each of the three areas (Clark, Washoe, and rural counties) indicates a critical need for expanded service capacity. Given Las Vegas's current and projected populations, there appears to be ample evidence to support two full community mental health centers for the metropolitan area.

RECOMMENDATION 25: *Expand the Reno Mental Health Center to a full community mental health center on the order of the one now operational in Las Vegas.* In the Washoe County area, the main problem with nonresidential mental health services is that a full continuum of services is not provided. The Reno Mental Health Center functions primarily as an outpatient program for adults plus a small day treatment and outpatient program for adolescents. Both the adult and adolescent programs are operating at full capacity, still not meeting the need, and people must be turned away. Day treatment for adults is not provided, nor are 24-hours-a-day emergency services or short-term residential care outside the NMHI in Sparks. Rural residents and mentally retarded residents are not now served. Population growth will significantly increase the need for a new community mental health

center before it can become operational. We do not believe the NMHI should function as a community mental health center for Washoe County; it has enough other functions (described later in this section) for which it appears better suited and which will use its staff to full capacity. The catchment area for the new community mental health center would be all of Washoe County plus the Lake Tahoe and Carson City areas, since we believe these would be better served by satellite offices linked to a community mental health center in Reno than by the Rural Clinics program, which does not provide a full range of mental health services.

When the northern Nevada Children's Behavioral Services (CBS) program is fully implemented, the Reno MHC Family Unit service program and staff for children and adolescents should work in close cooperation with it to maximize coordination of services and continuity of care for children and youth. If the northern Nevada CBS program serves only children under age 13, as the Clark County CBS program now does, there will be a need for services to youths aged 13 to about 18 that the Reno MHC program could concentrate on.

RECOMMENDATION 26: *Have the Children's Behavioral Services program provide more complete initial assessment of the mental health problems and service needs of the children it serves than it did in 1974, concentrate more of its resources on those children with the more severe mental health disorders than it did in 1974, and broaden the mix of professional skills on its staff to include specifically both physicians with specialty training in psychiatry and psychologists so that a more complete range of treatment modalities can be provided. The program in Clark County in 1974 was dominated by one mental health discipline (psychology) and one mode of treatment (behavior modification), which is not always the most appropriate mode of treatment for every mental health disorder. CBS might be fortunate enough to hire a physician with specialty training in both psychiatry and pediatrics; if not, then the program would also need to provide for pediatric services on at least a part-time consultant basis. In addition, some of the CBS client children whose cases we reviewed may not have had significant mental health disorders. The CBS program justifies serving children with mild behavior disorders by saying serious mental disorders are being prevented; while we fully support the goal of prevention, it is very hard to tell if a serious mental disorder would have occurred in a child with a mild behavior disorder if CBS had not served the child (see Chap. 5 of the main text, on Prevention, for a discussion of this issue area).*

The schools are not presently providing adequate special education for emotionally disturbed children. But even if they did, there would still be a need for nonresidential mental health services for the more severely emotionally disturbed children. Rather than make the schools take on the functions of mental health service agencies, recall our earlier recommendation for increasing the number of referrals of seriously emotionally disturbed children and youth in school, whether or not they are in special education, to the appropriate mental health center, Children's Behavioral Services program, or rural mental health clinic for service. The schools are not designed to provide every type of service well, nor should they be, since other service programs exist.

RECOMMENDATION 27: *Provide mental health services to mentally retarded Nevadans and their families if they need them. Such is usually not done now, and consequently a substantial gap exists in services provided for these people (see the next section on "Mental Retardation Services").*

RECOMMENDATION 28: *Substantially upgrade the skills of "mental health technicians" involved in treatment of mental health disorders by: (1) eliminating the existing personnel classification and creating three new classifications, one for those employees who primarily treat mental health disorders, one for those who primarily provide mental retardation services, and one for those who primarily perform non-treatment support functions such as clerical work, housekeeping, and patient escort; (2) upgrading the job requirements for the mental health treatment positions to the master's degree level; and (3) creating a training program at the University of Nevada at the master's degree level to provide people skilled in a broad range of mental health services to fill the mental health treatment positions. This recommendation is necessary because many mental health technicians, in both residential and nonresidential mental health programs, currently carry a heavy responsibility for direct treatment of people with mental health disorders, but many of them are seriously under-qualified or unqualified to fulfill that responsibility. The job requirements include only a high school education, plus experience and training for higher levels in the "mental health technician" job series. Unfortunately, the training of many technicians is clearly substandard. The officially required training levels are low to begin with. However, the Division of Mental Hygiene and Mental Retardation did not appear to have provided even those minimum amounts of training in most cases, and had certainly not adhered to the spirit of the training requirements. Each program is supposed to provide training for its own technicians. At the time of our interviews in 1974, we were told about the existence of some very brief training, but saw no high-quality, formal training program. For example, the Rural Clinics program (where mental health technicians directly treat mental health patients), provided no formal training program at the time of our interviews. A tendency we noted in some nonresidential mental health programs was for the program's administrators to tailor the services provided to fit the skill levels of their personnel, rather than tailoring their personnel to fit the greater service needs (either by revised hiring or revised training policies). Thus, some personnel who do not have the skills to help treat severely mentally ill people are assigned work for which they are more qualified (e.g., parent effectiveness training and premarital counseling), while people with more severe mental disorders go unserved. The new master's degree level of mental health personnel that we propose could be assigned the role of primary therapist (with appropriate professional supervision and support) and provide substantial meaningful treatment at relatively low cost compared with using only psychiatrists or Ph.D.-level psychologists in that treatment role. Recently, some improvement has been made by the Rural Clinics program overfilling some of its technician positions with master's degree level professionals. The NMHI Director also told us he is "proceeding to replace mental health technicians with more highly skilled professionals." As of February 1978, the NMHI had converted 2½ such positions. However, as detailed in Chap. 8 of the main text, the graduates of the proposed university-based work-study program would be skilled in a broad range of disciplines and services needed by people with mental health disorders; they would have significantly broader training than people with master's-level preparation in disciplines such as social work or psychology.*

Along with upgrading the skills of mental health technicians, certain other changes are necessary. It must be recognized that technicians who serve mentally retarded people need different skills from those of technicians who serve people with

mental health disorders; and both kinds of technicians should be free of many of the lesser tasks that mental health technicians currently perform, such as escorting people from place to place, and doing housekeeping and other tasks. Those tasks should not be done by technicians at the proposed master's degree level, but should be assigned to people with lower skill levels. We believe it is time for a frontal assault on the issue of quality of personnel; in Chap. 8 of the main text we propose a university-based work-study program to address this issue.

Finally, the above recommendation will not mean the elimination of all para-professionals from mental health service positions, which is neither desirable nor feasible.

Residential Mental Health Services

Residential programs required to meet the diverse needs of mentally handicapped persons range from full inpatient care programs to semi-independent residential living programs that offer minimal supervision and assistance. We focus here on *residential service* programs intended to provide more than the supervised *residential living* discussed later. For people with mental health problems, these residential service programs discussed here include: the Nevada Mental Health Institute's mental health programs, the Las Vegas Mental Health Center's residential treatment program; the new Children's Behavioral Services residential treatment program; local medical facilities with psychiatric units; the Nevada State Prison; the new Mentally Disordered Offender Facility; the Veterans Administration Hospital; and out-of-state residential treatment programs where Nevadans are sent when appropriate in-state services are not available for them. For a more detailed discussion and analysis of these programs than appears in this summary, see Chap. 10 of the main text.

For Nevadans with mental health disorders, approximately \$6 million was spent for residential treatment in FY 1974. The total full-time-equivalent staff numbered about 330. The daily average number of people in these residential programs was just under 300, and the total number of different service episodes (i.e., patient-stays at a facility) in FY 1974 was approximately 3300. The actual number of different people served is less than 3300, since some unknown number of people had more than one patient-stay at a facility or were served at more than one facility in FY 1974. In terms of daily average bed-capacity filled, the NMHI was the largest (160), followed by local and private general medical facilities with psychiatric units (64), and the Las Vegas Mental Health Center (30). In FY 1974 the Nevada state service system (i.e., all except local and private medical facilities with psychiatric units) accounted for about 78 percent of the utilized bed-capacity, 47 percent of the annual service episodes, 70 percent of the staff, and 52 percent of the expenditures. Thus, the state system is significantly less expensive per bed-year, but incurs about the same cost per service-episode since the service-episodes are longer than they are for local and private facilities. Such direct comparisons are difficult to interpret, however, because the types and severity of the mental disorders seen in the two sectors were quite different in FY 1974.

Since FY 1974, the residential mental health service system has been undergoing major changes: the geriatrics program at NMHI has been greatly reduced and the staff transferred to the NMHI neuropsychiatric program, which has decreased

the median patient-stay to 17 days in 1975; a new Mentally Disordered Offenders Facility has been constructed (bed-capacity 32); two Children's Behavioral Services residential treatment facilities are being created (each with a planned bed-capacity of 16); and the Rancho Vegas Nursing Center has planned to open a long-term psychiatric care section (bed-capacity 39). The probable net effect of these changes will be an increase in the utilized bed-capacity in Nevada of about 11. The prime reason the utilized bed-capacity will not increase substantially in spite of the new construction is that NMHI is substantially reducing the number of residents so that it can offer better mental health services to those who remain (the staff has not been reduced), and serve them in NMHI's better buildings.

We note that merely to maintain the 1974 level of service in 1985, the bed-capacity and annual budget of the residential mental health service system would have to be increased from 286 to 380 beds and from \$6.0 to \$8.0 million (in constant-value dollars).

Residential mental health services in Nevada are improving. The following recommendations are therefore intended not as criticisms of recent changes but as guidelines to further improvement. Three years ago, there were essentially no residential services in Nevada for children and youth with mental health problems, but the legislature has since approved three major new programs providing relatively short-term residential services (the Las Vegas Mental Health Center and the two Children's Behavioral Services programs); however, there is still a need for longer-term, in-state, intermediate levels of residential mental health services for children and youth. For adults, the NMHI, the prison, and a few local and private hospital beds existed three years ago, and the legislature since has approved two major new programs (the Mentally Disordered Offender Facility and the Las Vegas Mental Health Center adult program); however, there is still a need for short-term residential capacity in conjunction with the two improved mental health centers we recommended earlier. The recent massive shift of the mental health section of NMHI from a mixture of chronic and acute care toward short-term acute treatment has left those adults in need of intermediate-level chronic care inadequately served.

The two newly approved Children's Behavioral Services residential facilities help fill a gaping hole in the Nevada mental health residential service system for young people, and we fully endorse them. In 1974 there was no residential mental health treatment program for children and youth, either public or private, in northern Nevada. The only public mental health facility in the entire state that accepted youth on a residential basis was the Las Vegas Mental Health Center, and it usually accepted only youth over 12 years old from the Las Vegas area. Consequently, 20 to 30 of those children with the severest mental problems requiring residential treatment were sent to mental facilities out of state. (Forty-five were placed out of state in December 1975.) Other less fortunate children were not served at all. Still others ended up in places such as the state juvenile training centers or the state children's homes, which are not intended to offer mental health treatment programs.

RECOMMENDATION 29: *The two Children's Behavioral Services (CBS) residential treatment programs should be adequately and unconditionally staffed, specifically including positions for both physicians with specialty training in psychiatry and psychologists so that a more complete range of treatment modalities can be provided; the Reno CBS residential facility should serve children and youth through*

age 18; and both facilities combined should accept rural children so as to prevent differences in the level of service per capita between the Las Vegas, Reno, and rural areas of Nevada. When construction is completed on the CBS residential facilities in Reno and Las Vegas, the lack of residential mental health services we noted above for youngsters in Nevada will be partially rectified. However, the CBS facilities are small and the program in the south accepts only 12-year-old and younger children, while the Las Vegas Mental Health Center serves those over 12. If the CBS program in the north accepts only 12-year-olds and younger, there will still be no residential mental health program for children over 12 years old in northern Nevada, since the Reno MHC currently has no residential capacity and NMHI does not serve children. Also, both the northern and southern Nevada CBS, and the Las Vegas MHC, residential programs will provide only relatively short-term, intensive residential services and short-term transitional residential placement with specially trained "professional parents"; any child who cannot live in his or her own home or in a foster home over the longer term will not have longer-term, in-state, intermediate levels of residential mental health services available. (This problem is dealt with in recommendation 32.) In addition, emotionally disturbed youth in rural areas need provision for residential services from the CBS or some other program and outpatient services from an upgraded Rural Clinics program. Finally, the CBS nonresidential program in Las Vegas currently does not provide a full range of treatment modalities to meet the range of children's needs; rather, it focuses primarily on the behavior modification mode of treatment.

RECOMMENDATION 30: *Correct the major deficiencies noted in the Joint Commission on Accreditation of Hospitals (JCAH) accreditation report for the mental health section of the NMHI. Although the mental health section is accredited, NMHI's mental health program still has major deficiencies that must be corrected to improve the quality of services and to maintain JCAH accreditation.*

A major problem exists with the quality and quantity of psychological services provided at NMHI. The psychiatrist in each NMHI neuropsychiatric unit is able to spend an average of only about one-half hour per week in direct contact time per patient, exclusive of record-keeping (recall the median stay of 17 days). Other staff members therefore carry a heavy responsibility for patient treatment. Since the units have no regular full-time direct-patient-service psychologist and since the social worker has other responsibilities, a heavy load rests on the one supervisory psychiatric nurse and the unit's mental health technicians who are assigned as each patient's "primary therapist." As indicated above, however, the technician's job requires only a high school education, and at the time of our interviews their training was grossly inadequate; there was no formal training program for all the technicians at NMHI (contrary to the officially stated job requirements). Consequently, most of the mental health technicians, although hardworking and dedicated, are not skilled enough to adequately do the work they are responsible for. The upshot is that psychopharmacological intervention (drug therapy) appears to be the primary mode of treatment for most mental health patients at the Institute. However, psychopharmacological intervention is primarily useful as an adjunct to other kinds of treatment (e.g. psychotherapy), which it may facilitate but does not replace. Essentially the same lack of skills and training of technicians prevails in the Las Vegas Mental Health Center residential treatment program. Recall our earlier recommendation for upgrading mental health technician skills to resolve this situation for both nonresidential and residential mental health programs.

In addition to the deficiencies in mental health services within NMHI noted above, another major deficiency of the NMHI mental health program in mid-1974 was in the area of postdischarge follow-up treatment. Continuity of care and adequate followup treatment after discharge from NMHI was the exception rather than the rule in 1974, although some significant improvements have been made since then. This is a major problem with the state's mental health service system, since two primary objectives of inpatient treatment are (1) to help the patient through a severe mental health crisis (a few days' treatment will usually help a patient past an episode of acute decompensation), and (2) to engage the patient in a treatment process that will continue and will address the basic problems that made him or her vulnerable to the acute decompensation. Whereas the first objective can usually be satisfied in a brief hospitalization of a few days' duration, the second objective usually requires substantial treatment extending beyond the period when residential inpatient treatment is required. Psychotherapeutic services, for example, usually cannot be satisfactorily completed within a 17-day period (the median NMHI length of stay.)

The Reno Mental Health Center's lack of adequate follow-up (other than drugs) in 1974 has led the NMHI to attempt its own follow-up in the Reno area, but the limited NMHI staff has enough difficulty merely providing its residential services. The Rural Clinics personnel were not providing adequate follow-up for most rural residents discharged from the Institute, and it is doubtful that they have the personnel to do so and also fulfill their other responsibilities. For Clark County residents, the transition is abrupt from the Institute to the Las Vegas Mental Health Center, but the center can provide adequate follow-up services and has recently developed an "Advocacy/Aftercare Program," which provides follow-up services to former inpatients of the Las Vegas MHC and the NMHI, and generally monitors and implements continuity of care.

RECOMMENDATION 31: *Implement improved follow-up treatment to provide a continuity of care for mental health patients released from NMHI; mandatory improved follow-up procedures also should be established to help ensure that people released from other state-operated residential mental health treatment programs (Las Vegas MHC and CBS programs) receive adequate follow-up services. This includes both short-term and long-term follow-up, e.g., for people who have a chronic need for some intermediate level of mental health services and are residing in extended care facilities that do not provide those services. The expanded mental health centers and Rural Clinics program staff improvements we recommended earlier are necessary to provide fully adequate follow-up treatment for NMHI ex-patients, since outpatient services are not in adequate supply and day treatment services are nonexistent outside the Institute in most geographic areas (particularly in rural counties and Washoe County).*

Since changing a patient's primary therapist in the transition from residential to nonresidential service is difficult and can disrupt treatment, it ideally would be preferable to have the same primary therapist in both the inpatient and nonresidential phases of treatment. Professionals such as psychiatrists or Ph.D.-level psychologists could be used as the single primary therapist in all phases of treatment. However, the new master's degree level of mental health service personnel we recommended above could be assigned the role of primary therapist (with appropriate professional supervision and support) and provide substantial treatment at rela-

tively low cost compared with using only psychiatrists or Ph.D.-level psychologists as primary therapists.

Recall our earlier recommendation that two new community mental health centers be created, one in the Las Vegas area and one in the Reno area. These centers would include provision for short-term (a few days or weeks) inpatient treatment, as well as day, emergency, and outpatient treatment. About 100 new bed-spaces will be required by 1985 merely to maintain the present level of residential mental health service capacity on a per capita basis in Nevada.

The Las Vegas Mental Health Center's residential treatment program had a number of problems in 1974. In our view, they stemmed from the newness and rapid startup of the program, from the fact that it was not yet fully professionally staffed when we interviewed, and from the low skills of the mental health technicians. Time and administrative attention should take care of the former two reasons (in fact, the Center's administrator indicates that the "vast majority" of the Las Vegas MHC professional positions are now filled), and the latter reason is the subject of our earlier recommendation regarding upgrading mental health technicians' skills throughout all programs.

A major problem with Nevada's mental health service system is the nearly total lack of intermediate services between full inpatient treatment and outpatient treatment. For example, service system capacity is lacking in the areas of halfway houses, day treatment facilities, and chronic care programs that provide more than drugs. Most mental health care in Nevada today is episodic, and little or no intermediate-level aftercare is provided following discharge from residential treatment. The lack of day treatment facilities would be alleviated by the two new community mental health centers recommended above. Chronic care programs and halfway houses are discussed below.

A large remaining gap in the mental health service system is in service to people with chronic mental health problems. Ironically, this gap was created for adults only recently by an administrative policy shift in the type of residential service to be provided by the NMHI (from chronic and acute toward primarily short-term acute mental health service). In reducing the number of mental health residents at NMHI from about 380 to less than 100, long-term patients receiving chronic residential care were released to the care of their families or other residential facilities that usually have no mental health services (e.g., intermediate care facilities, nursing facilities, and adult group care facilities). Other than the prescription of drugs, periodic visits by an NMHI nurse to those other residential facilities, and psychiatric consultative services provided on request to three skilled nursing facilities in the Reno area, there is no follow-up. These long-term patients apparently were released for a variety of reasons, including: lack of need by most of the long-term patients for the full intensive inpatient treatment the NMHI administration wants to provide; and the recent substantial reduction in the number of NMHI residents allows better mental health services to be provided to the smaller number of patients remaining and needing full intensive inpatient treatment. The follow-up has improved since 1974, but there still is a gap in the service system between the full intensive inpatient level of treatment NMHI now is supposed to provide and the level of essentially no mental health treatment for mentally disordered people living with "normal" people in nursing homes, group care homes, or with the person's family.

RECOMMENDATION 32: *Create mental health service programs for children and adults that provide an intermediate level of mental health services over an extended period of time to people with chronic mental health disorders.* Both children and adults may need this type of extended-term intermediate level of mental health services: the service system should provide for serving people in both age groups in separate programs. This should not be a long-term hospitalization or institutional program. It could be a program providing substantial outpatient, day treatment, and other services (as appropriate to the individuals' needs) for people residing in various types of supervised facilities in the community. This intermediate care program would provide some direct mental health services (more than drugs) and some of the residents would be free to move about in the community. The lack of such a program has resulted in some children and adults not being served, other people cycling from agency to agency (one such person reportedly cost the service system between \$30,000 and \$40,000 in one year), and children being sent to institutions out-of-state. For children and youth, the two new CBS facilities and the Las Vegas Mental Health Center provide for relatively short-term residential mental health needs. William LaBadie, of the Nevada Welfare Division which is responsible for children placed in out-of-state institutions, indicated that "the problem is that the Division of Mental Hygiene and Mental Retardation views these residential facilities as only very short-term. Without some type of residential intermediate mental health facility, the state would continue to be faced with the problem we have presently. Not only would the number of children in out-of-state placement not be reduced with the increasing population, the numbers would be increased."

RECOMMENDATION 33: *Create halfway houses operated in conjunction with mental health centers in both northern and southern Nevada for people with mental health disorders.* The mental health centers could provide substantial outpatient, day treatment, and other services (as appropriate to the individual's needs) for people residing in these halfway houses. Halfway houses provide a community-based intermediate level of residential service for short periods (weeks or months) for people released from residential intensive treatment programs but still incapable of living independently in the community. Halfway houses also provide an alternative to hospitalization. In 1974, we were aware of no such houses in the entire state for people with mental health disorders. A small transitional facility is planned for the NMHI, but it can hardly be called community-based. These halfway houses not only would provide a missing level of needed service and a means of avoiding unnecessary hospitalization or unnecessarily extended hospitalization, thereby improving the quality of people's lives, but also would be much less expensive than full residential treatment programs.

We found conditions for mentally handicapped people at the Nevada State Prison in mid-1974 to be extremely bad. The state has recognized the severe problem of lack of psychiatric treatment for prisoners with mental health disorders, and has acted by beginning construction on the new 32-bed Mentally Disordered Offender Facility. We endorse this greatly needed new mental health program. However, the current number of Nevada prisoners in need of mental health services exceeds the bed-capacity of the Mentally Disordered Offender Facility, and the rapidly expanding population of the state is likely to be accompanied by a rising population of mentally handicapped prisoners. The courts recently ordered that certain types of prisoners be evacuated from the prison's "psychiatric unit," but most mentally ill

prisoners were not on that unit. The stated intention of the Division of Mental Hygiene and Mental Retardation is to use the Mentally Disordered Offender Facility for treatment of a "relatively short-term nature" and then to return the individual to "his natural environment or the criminal justice system." Consequently, because of the small size of the Mentally Disordered Offender Facility, it is clear that at least follow-up mental health services will have to be provided to some people who are returned to the Nevada State Prison following intensive treatment at the new facility. The Clinical Director of the new facility acknowledges that it "cannot handle all of the mental health problems (broadly defined) of the State Prison." The new facility's small size is acceptable, provided the rest of the mental health service system operates appropriately. If all prisoners with mental health problems are to receive the services they need, we believe it essential to implement the following three recommendations.

RECOMMENDATION 34: *Use the Mentally Disordered Offender Facility primarily for treatment of prisoners with mental health disorders, and not (as some state personnel have considered) for persons who have neither been charged with nor convicted of crimes but who need treatment in a secure facility.* In a March 4, 1976, letter to Rand, R. Hiller, the Clinical Director of the new facility, indicated that "its purpose is quite clearly to serve those individuals who have been in contact with the criminal justice system."

RECOMMENDATION 35: *Make provision for mental health services within the Nevada State Prison for mentally disordered prisoners who do not need the intensive level of treatment provided by the Mentally Disordered Offender Facility, or who need follow-up services after intensive treatment at that facility.* Providing services at the new facility will solve only part of the problem; there should be no false impression that a new small facility can furnish adequate services to all mentally disordered prisoners. To provide those services within the prison, additional mental health staff positions will be required; we suggest that those staff members be under the direct supervision of the administrator of the Mentally Disordered Offender Facility rather than under the sole supervision of the warden.

RECOMMENDATION 36: *Assign the Nevada Mental Health Institute the responsibility for providing a secure neuropsychiatric unit for those patients who need it and have not been charged with or convicted of crimes.* While drugs and other therapy have in most cases eliminated the need for physical restraints at the Institute, some patients need a locked unit or area where they can be monitored to help prevent them from physically abusing themselves or other patients, and to restrain them from leaving the Institute. The Mentally Disordered Offender Facility already has more than enough responsibility and should not have to serve patients the Institute could adequately serve.

The median length of stay for discharged NMHI mental health patients was about 17 days in 1975. In those terms at least, the Institute is now primarily functioning much the same as the inpatient units at Washoe Medical Center, Southern Nevada Memorial Hospital, and the Las Vegas Mental Health Center. The Institute currently is not functioning primarily as a place for treatment of patients needing more prolonged care than that typically provided by those three mentioned community-based facilities. Having described problems with the various residential mental health service programs and made some recommendations for improvement, we can now summarize what we believe to be the most appropriate functions for the NMHI.

RECOMMENDATION 37: *Use the mental health section of the Nevada Mental Health Institute for inpatient mental health treatment for rural Nevadans, for those who need a secure facility, for those who need more than short-term residential treatment at the mental health centers, and for those unable to enter the inpatient units of mental health centers because the units are temporarily filled to capacity. Thus, we see the mental health section of the current NMHI facility as complementing the state's community mental health centers in the overall service system, rather than acting as a community mental health center itself (although the recommended new Reno area community mental health center might be located at or near the Institute). Each of the four service functions mentioned in the above recommendations for NMHI is essential and is not now being filled adequately by the state's mental health centers. Of course, one could define other functions for the soon-to-be-improved Institute facilities, but some other facility or facilities would still have to provide the four service functions we outlined for NMHI. The Las Vegas Mental Health Center does not have the bed-capacity to provide both short-term and longer-term residential services (by longer-term we mean here 3 to 12 months, only occasionally more); the Institute has a larger capacity and a secure facility capacity, which it would seem wasteful not to use since funds for new construction are very limited. One could also recommend a second Nevada Mental Health Institute in southern Nevada; while that may be justified at some future point in Nevada's population growth, it seems unnecessarily expensive now in relation to other needs.*

Given the sparse populations in rural areas of Nevada, no single rural area currently appears capable of fully using an intensive inpatient mental health treatment facility. We believe that rural Nevadans can be more effectively and less expensively provided with intensive residential mental health services in one of the urban areas. Provision should be made to assure rural Nevadans of access to those services, including transportation to urban areas if required. Rather than have rural Nevadans compete with urban Nevadans for available bed-spaces in each of the mental health centers, it may be preferable to designate one facility to be responsible for residential mental health services to rural Nevadans. We suggest the Institute be so designated, since the only existing mental health center with residential capability already is supposed to serve the half of the state's population concentrated in the Las Vegas area.

RECOMMENDATION 38: *Establish an improved information system for monitoring and managing mental health program operations as well as the effectiveness of services. The deficiencies in existing information make it difficult to effectively manage, plan, and evaluate service programs for people with mental health disorders. Needed information improvements are described in Chaps. 4, 8, and 10 of the main text.*

For a more detailed discussion of nonresidential and residential mental health services, see Chaps. 8 and 10, respectively, of the main text.

MENTAL RETARDATION SERVICES

Nevada provides a broad range of residential and nonresidential programs to meet the diverse needs of mentally retarded people, although not every program has enough service capacity. Programs for Nevadans discussed in this section include inpatient care in the mental retardation section of the Nevada Mental Health

Institute, residential care at the small private Eagle Valley Children's Home, intermediate levels of residential care at the Northern and Southern Nevada Mental Retardation Centers, a range of levels of residential and nonresidential services at the Desert Developmental Center to be constructed soon, and out-of-state residential treatment programs to which a few mentally retarded youths with mental health disorders are sent. For a more detailed discussion and analysis of these programs than appears in this summary, see Chap. 10 of the main text; for an economic benefit/cost analysis of various services for mentally retarded people, see Conley's work cited in the "Prevention" chapter of our main text. In other sections of this summary, we discuss various additional programs that provide mental retardation services to people with higher levels of functioning who do not need the more service-intensive programs listed above, e.g., the Community Training Centers program, which provides prevocational and vocational services, and the Developmental Homes, which provide community-based residential living.

About \$2.3 million was spent for residential programs for mentally retarded Nevadans in FY 1974. The total full-time-equivalent staff was about 180. The daily average number of people in these residential programs was just over 200, and the total number of different people served in FY 1974 was probably not over 250 since most were long-term residents. In terms of utilized bed-capacity, the NMHI was largest (140), followed by the Mental Retardation Centers (54); the one private facility had only about 10 residents. In FY 1974, the Nevada state service system (which includes all but the Eagle Valley private facility) accounted for over 95 percent of the staff and expenditures and of people served.

Since FY 1974, the residential mental retardation service system has begun major changes: a new Desert Developmental Center is being constructed in Las Vegas (bed-capacity 56); when it opens, the NMHI mentally retarded resident population will be cut to less than half of the FY 1974 level. The plan is to reduce the number of residents at NMHI without reducing the staff, so that those remaining can receive better services and can be served in improved facilities. With these and other changes, the NMHI may be able to achieve accreditation from the Joint Commission on Accreditation of Hospitals as a mental retardation facility.

To maintain the 1974 quantity of residential service per capita for mentally retarded Nevadans in 1985, the service system's bed-capacity would have to increase from 208 to 276 and the annual budget from \$2.3 to \$3.7 million (in constant-value dollars).

Residential mental retardation services are improving in Nevada and current staff people by and large are dedicated and hardworking. Adequate services are still a far-distant goal, however.

RECOMMENDATION 39: *Improve the NMHI mental retardation program to meet JCAH accreditation standards.* The greatest inadequacy in the present system is in the NMHI Mental Retardation program. The program twice has failed to receive accreditation by the Joint Commission on Accreditation of Hospitals (JCAH), for a large number of reasons, mostly stemming from a staff that is deficient in numbers, training, and mix of professional skills, and consequently unable to provide adequate services to residents. (See Chap. 10 and Appendix B of the main text for details.) The facility improvements at NMHI and the new Desert Developmental Center approved by the 1975 Nevada Legislature will help upgrade the NMHI program by improving physical living conditions at NMHI and by cutting the NMHI

resident population approximately in half as residents are transferred to the new center. Since 1974, the Nevada Mental Health Institute's mental retardation program has made internal changes that have changed the quality and quantity of services provided for the current residential population. These changes have been implemented using the JCAH accreditation standards as a guide and are seen by NMHI only as beginning steps that are necessary to ultimately bring the residential program into compliance with accreditation standards. An attachment to a letter from NMHI Director T. Piepmeyer to Rand on February 27, 1976, stated that "these program changes are pitifully inadequate unless additional resources outside the existing program are obtained in the form of staff, training and proper mix of professional skills." The two primary internal changes using existing staff are a new day training center and an interdisciplinary committee to evaluate and plan services for each individual resident.

RECOMMENDATION 40: Given the extensive service program planned and needed for the population of more severely mentally retarded southern Nevadans, and given the new facility approved by the legislature in 1975, the Desert Developmental Center staff should be approved by the legislature in 1977; when that center's staff is approved, the mental retardation staff of the NMHI should not be cut, so that the Institute will then be able to provide more nearly adequate services to the mentally retarded residents remaining there. Interdisciplinary NMHI teams have been functioning since March 1975; 86 of the 108 persons now in NMHI's mental retardation program have been reviewed, individual client needs identified, and a corresponding treatment/training plan has been developed for each of them. About 50 percent of the activities identified in these plans have been deferred due to inadequate staff, according to an NMHI administrator.

RECOMMENDATION 41: Provide services through the NMHI and the Northern Nevada Mental Retardation Center for northern Nevadans equivalent to those services that the new Las Vegas Desert Developmental Center will provide for southern Nevadans; defer approval for the construction of the northern Nevada equivalent of the Las Vegas Desert Developmental Center facilities until other higher-priority expenditures have been made. We agree that the concept of a new northern Nevada equivalent of the Desert Developmental Center is a good idea and that improved services should be provided, but we question the priorities and timing on the facility construction. The Institute already exists; on the other hand, facilities are either totally absent or too small for services to some other groups of mentally handicapped people, and for some other types of services for mentally retarded people. It seems to us that first priority on new facility construction should go where none exists at all, rather than where facilities exist that could be improved. We do not mean to imply that the Institute's mental retardation facilities are good enough or that we condone the inferior services its residents now receive. Rather, we believe that services for mentally retarded people in northern Nevada can be sufficiently improved within the existing facilities at the NMHI and elsewhere in the Reno area, so that construction of new facilities can be deferred while other higher-priority needs are met.

RECOMMENDATION 42: Separate control of the mental retardation program from that of the mental health program at the Nevada Mental Health Institute, and give it to the Associate Administrator for Mental Retardation of the Nevada Division of Mental Hygiene and Mental Retardation. This would consolidate, in one person,

responsibility and accountability for all mental retardation programs in the Nevada Division of Mental Hygiene and Mental Retardation. This also is in recognition of the separate spheres of activity that now exist at NMHI and compete for resources. We do not envision physically removing all mentally retarded people from the current NMHI site now, although that might be done in the future. The intent of this recommendation is to consolidate the administration of, and responsibility and accountability for, mental retardation programs. At present, the largest residential program for mentally retarded people in the state is not the responsibility of or within the direct sphere of control of the DMHMR Associate Administrator for Mental Retardation; this seems to be an unnecessary and undesirable disaggregation of responsibility and accountability. Auxiliary services and facilities for mentally retarded residents at NMHI, such as medical care and recreational facilities, could be obtained from the non-mental-retardation portion of NMHI as they are now, but the NMHI Director would retain no control of the mental retardation program; NMHI's bookkeeping system is such that it would not be overly difficult to arrange for the appropriate interprogram transfer of funds.

RECOMMENDATION 43: *Provide the state technician staff working with mentally retarded people with improved formal training in the provision of developmental services.* The current training for state-employed mental health technicians at the Mental Retardation Centers and the NMHI is inadequate, and in practice even falls short of the officially stated job requirements. Recall our earlier recommendation for splitting the mental health technician job classification into three new classifications, one of which could be an upgraded mental retardation service specialist.

Virtually no mental health services (other than drugs) are provided to mentally retarded people living at the NMHI, the two Mental Retardation Centers, or anywhere else in the entire state. As argued in the "Desirable Features of a Psychological Service System" section of Chap. 8 of the main text, no single mode of treatment, such as chemotherapy, is the most appropriate for every mental health disorder. Although not all mentally retarded people and their families need mental health services, some clearly do. Recall our earlier recommendation that provision be made for mental health services to those mentally retarded people and their families if they need them. A difficulty that must be overcome, however, is that the mental health service system in practice seldom serves mentally retarded people and is separate from the mental retardation service system, which itself typically does not hire mental health professionals who could provide psychotherapy or other modes of treatment.

RECOMMENDATION 44: *Provide nearly all Eagle Valley Children's Home residents with needed special education and training through the Carson City School District.* At the private Eagle Valley Children's Home, which primarily serves severely and profoundly retarded youth, only three of the ten residents were receiving special education and training in September 1974. However, nearly all residents need those services. An additional special education unit (\$16,000) should be provided by the Nevada Department of Education for that purpose, since not all the home's residents originally come from Carson City.

RECOMMENDATION 45: *Mentally retarded prisoners should be identified and a special program of services should be established for them.* At present, the Nevada State Prison system has no idea how many prisoners are mentally retarded, and provides no special services for them, other than allowing them to participate in

basic adult and remedial education classes. To some unknown degree, special services would certainly improve the quality of their lives and their level of functioning following release from prison, and would probably reduce the incidence of their commission of crimes.

On the matter of geographic availability of services, we note the persistent tendency in Nevada to plan and approve facilities of the same size in Reno and Las Vegas (e.g., the Mental Retardation Centers and the Desert Developmental Centers), and to build no residential mental health and mental retardation treatment facilities in rural Nevada. We believe those practices are largely justifiable, as long as the service system is so administered that rural Nevadans have access to the Reno and Las Vegas facilities. The rural population is sparse, only a few people need residential services in any single rural locale, and it is both costly and difficult to maintain professional staffing and specialized services in small rural facilities. Given that the Reno and rural populations are about the same size, and that the Las Vegas population is about equal to the Reno and rural populations combined, it is equitable to build equal-size facilities in the north and south only if each area gets its fair share of the service. In practice this means that about half of the Reno facility should be devoted to serving rural Nevadans, most of whom live in northern Nevada. Less service-intensive and longer-term residential living (e.g., developmental homes) could still be provided in rural Nevada (see Chap. 13 of the main text).

RECOMMENDATION 46: *Establish an improved information system for monitoring mental retardation program operations, including the effectiveness of services.* During 1974 the Division of Mental Hygiene and Mental Retardation began to use a computerized, individualized data base for mentally retarded clients of certain division programs. This data base is sufficiently detailed to provide not only data and reports on clients or groups of clients and the services they are receiving, but also information on clients' functional abilities that could be used for program evaluation. In mid-1974, this data system had at least partial information on over 375 mentally retarded clients of the division. This computerized data base appears highly desirable in theory, and with privacy safeguards, we endorse it or one with similar objectives tailored specifically to Nevada's needs. Two improvements would be desirable, however. First, to be of most value, the data base should not be limited to Division of Mental Hygiene and Mental Retardation clients, but should also include retarded people served by other programs, e.g., Department of Education, Division of Health, Division of Welfare, and Division of Rehabilitation. Second, the mid-1974 Plan was to use a computer in Pomona, California, with information transferred by mail. It would be desirable to have the data base on a Nevada computer, where it can be used more readily and can be tailored to Nevada's needs. The data base should be associated with the Regional Direction Centers we recommended above, if those centers are created.

For a more detailed discussion of mental retardation services, see Chap. 10 of the main text.

ALCOHOL AND DRUG ABUSE SERVICES

Prior to the 1960s, most mental health professionals considered alcohol and drug abuse a form of mental pathology. Consequently, it was often treated in the same

facilities and with the same techniques used for mental illness. But the past decade has witnessed a major transition. There has been a growing conviction that while the onset of excessive drinking or drug use may ensue from a psychological crisis of some sort, the addiction process once set in motion has its own mechanisms that go beyond the earlier psychodynamics. The release from addiction therefore may require treatment processes relatively independent of those necessary for the earlier psychological problems. Also, many alcohol and drug abusers have strongly resisted being classified as mentally ill, and will avoid treatment in a setting which allows such identification to take place. Consequently, most drug and alcohol treatment is now administered in separate facilities by a specially trained staff, a trend likely to continue.

The alcohol and drug abuse treatment programs in Nevada spent about \$2.6 million last year, including over \$1.1 million for alcohol abuse and over \$1.4 million for drug abuse. At least 700 alcoholics and 300 drug addicts received substantial service last year from these treatment programs; in addition, more than 700 persons participated in Alcoholics Anonymous in Nevada. Alcohol and drug abuse education programs reached many more.

Investigation of the service delivery system for alcohol and drug abuse treatment has revealed a number of gaps between people's needs and services available in current programs. Service delivery system problems fall into three categories: inadequate information, organizational problems, and facility and service deficiencies. For a more detailed discussion of the current alcohol and drug abuse treatment programs and their problems, see Chap. 9.

We summarized the deficiencies in information on rates of alcohol and drug abuse in Chap. 1. The second information gap has to do with the current service delivery system. There is inadequate systematic detailed data collection on client loads, staffing patterns, service capacity, and the like for treatment programs throughout the state. Intelligent planning under such circumstances is very difficult. In sum, the state has too little routine program-management information, and too little information on program results—clients' conditions following release from treatment—to use in program evaluation. The Bureau of Alcohol and Drug Abuse is working diligently to resolve this information problem: a new data collection and processing system is being developed and federal funding to assist in this area has been applied for.

Organizational problems involving overlapping or ambiguous responsibilities persist even though the state Bureau of Alcohol and Drug Abuse was created to consolidate formerly fragmented units within the state government into a single coordinating state agency. One overlap involves the state bureau and some of its own creations, the local umbrella coordinating organizations. Basically, both groups now seem to have responsibility for and provide some overall coordination of community programs. It is not clear why the central office in the Reno area cannot handle Washoe County coordination, nor why the Las Vegas branch office cannot handle coordination for that area. The umbrella organizations, as they are presently constituted, appear to be an unnecessary bureaucratic layer between the local service delivery agency and the state bureau, which provides no service directly to alcohol and drug abusers. We do not mean to imply that there is no need for local advisory councils representing local treatment agencies, but this is not what the umbrellas appear to be now, since their boards of directors do not include all heads of local

treatment agencies. A second overlap occurs because all "health care" facilities must obtain licenses from the Nevada Division of Health, with issuance contingent on approval by the county health planning people. On the other hand, the state Bureau of Alcohol and Drug Abuse has been given responsibility for certifying alcohol and drug treatment programs, personnel, and facilities. A third overlap arises out of the continuing responsibility of the Nevada Mental Hygiene and Mental Retardation Division for the Nevada Mental Health Institute and its Ward 10 alcohol abuse program. Thus far the overlap has not led to overt conflict; NMHI and the state bureau seem to go pretty much their own ways. In any event, complete coordination of alcohol programs will be difficult so long as one of the main treatment programs functions outside the main delivery system. Finally, there is an administrative problem. Although consolidation of drug and alcohol program coordination within a single agency makes for some bureaucratic efficiency, especially in a small state like Nevada, it must be recognized that, at the local level, separate agencies normally will handle alcohol and drug treatment. Accordingly, any coordination effort must recognize that separation if it is to be efficient and successful.

In terms of expenditures per alcohol abuser, it appears that Nevada is receiving (or at least spending) less than its fair share of federal funds for treatment of alcoholism, and is spending much less in state funds per alcohol abuser than is neighboring California. From a regional standpoint, considering expenditures in relation to the number of alcohol abusers in the region, it is clear that the Las Vegas area and rural regions are not nearly as well funded as the Reno area.

Some specific facilities also are needed. A general problem in both alcohol and drug abuse treatment in Nevada is the absence of a comprehensive service system that offers a full range of levels of service that can be selected from to meet a particular client's needs, including detoxification, inpatient treatment for alcohol or drug abuse, halfway or rehabilitation house service, and outpatient therapy or counseling. Certain elements on the "continuum of care" are not present in Nevada or are not present in sufficient capacity. Nonmedical detoxification facilities are one such element that is either not present in certain geographic areas or is not present in sufficient capacity. Aside from a statewide deficiency in detoxification facilities, there is a deficiency of outpatient care in the Reno area for alcohol abusers as compared with the relative predominance of halfway or live-in rehabilitation houses. Alcohol abuse service system capacity of all types is deficient in Las Vegas and in rural areas. In Las Vegas, for example, halfway or live-in rehabilitation houses for alcohol abusers are in particularly short supply, and the area does not have an alcohol abuse treatment program analogous to that provided by NMHI which is accessible to people who cannot afford private treatment. Finally, there are staff training needs in the facilities that do exist.

As with alcoholism, there are insufficient detoxification facilities for drug abusers. Reno has no professionally staffed program for the hard-core addict. (The NMHI Ward 10 program is designed for alcohol abusers.) The drug abuse treatment system also has some other kinds of facility problems. There is no full inpatient care program in the state analogous to the NMHI Ward 10 program but designed for drug abusers. Regarding halfway or live-in drug rehabilitation houses, it is a matter for concern that some of the live-in drug treatment facilities in the Las Vegas area are operating at less than capacity and a few have been embroiled in controversies about alleged drug use by people associated with those facilities.

In making these recommendations we recognize that organizational structures and service programs are still evolving in this area. Some of these developments are reflected in the 1975 *Nevada State Plan for Prevention, Treatment and Rehabilitation of Substance Abuse*, in particular the detailed planning for the proposed detoxification program for Washoe County sponsored by NASAC. But most of our recommendations, while consistent with goals in the state plan, are not yet implemented and not yet reflected in current detailed planning, especially those pertaining to Clark County—which encompasses between one-half and two-thirds of Nevada's alcohol and drug abusers. We are also concerned that the 1975 state plan reflects continued use of the words "Drug Abuse Council" in the SNDAC name (with no mention of alcohol), by its failure to propose realistic detailed plans for implementation of service program improvements for Clark County alcoholics, and by its use of underestimated alcoholism incidence rates, rates that are well below even the most conservative estimates available using NIAAA methods of estimation.

RECOMMENDATION 47: *Establish comprehensive information systems for monitoring alcohol and drug abuse treatment programs, as well as alcohol and drug abuse rates.* Better information on current programs and abuse rates would not only make better management of current programs possible, but would also enhance the quality of planning for future programs. For alcohol abuse rates, it should be easy to tabulate cirrhosis deaths and beverage sales on a county-by-county basis and thus to make estimates of abuse rates like those made in Chap. 3 of the main text to assist in regional planning. For drug abuse rates, the state should look into methods used by the National Institute on Drug Abuse. Information for monitoring service programs should be required from every local program receiving federal or state funds, and should be requested from all others (e.g., detailed information on expenditures, staff, services, number and type of clients, and program effectiveness).

RECOMMENDATION 48: *Consider a more streamlined organizational structure for alcohol and drug abuse services that will eliminate overlapping jurisdictions on the one hand and recognize separate spheres of activity on the other.* A key feature of the arrangement we envision would be the creation of two councils, one for drugs and one for alcohol, in each of three regions: Clark County, Washoe County, and the remaining, predominantly rural, region of the state. Council membership would include all local treatment program directors (or perhaps a rotating subset) and selected local officials and leaders (e.g., representing the public, police, courts, schools, city councils, etc.). The regional council's main function would be to advise the state on planning for future services, current financial assistance, and certification, and to improve local coordination. In this way, some of the functions of the county Comprehensive Health Planning agency and the present umbrella organizations could be consolidated into a single structure. We are not criticizing the concept of an umbrella organization, but rather the way the current umbrella organizations have been designed by the state Bureau. For example, representation on the councils could be broader than it is in the present umbrella organizations. Certain functions of the umbrella organizations, such as acting as a funnel for funds, seem unnecessary in a state the size of Nevada, which has a functioning state Bureau of Alcohol and Drug Abuse; hence those functions would be abolished. The separation of drug and alcohol councils recognizes the current realities of separation of both the local treatment organizations and the federal financing agencies. It also should solve some of the local conflicts that have been observed since the creation of the currently

existing umbrellas, which now cover both alcohol and drug services with a single local organization. There may be a need of state funding for staff to support the councils' activities, and the councils may be the appropriate agency to apply for certain federal funds.

A second major feature of the reorganization would be the transfer of control of the NMHI "Ward 10" to the Bureau of Alcohol and Drug Abuse. (We recognize that such a transfer may require legislative action.) We do not envision removing the Ward 10 program from the NMHI site at the present time, although that might happen in the future. Instead, we would give administrative and budgetary control of the alcohol and drug abuse treatment program to the alcohol and drug abuse agency rather than to the Mental Hygiene and Mental Retardation agency, which has different priorities. Auxiliary services and facilities for Ward 10 patients, such as medical care, recreational facilities, and "industrial therapy" (jobs) could be obtained from other portions of the NMHI as they are now. The bookkeeping system at NMHI is such that it would not be too difficult to arrange for an interagency transfer of funds to cover those services and the use of facilities.

We are not necessarily arguing that direct clinical supervision of Ward 10 be placed at the Bureau of Alcohol and Drug Abuse, since its present structure may not include sufficient professional staff for such responsibilities. Rather, we are recommending an administrative and budgetary realignment, since we do not see how full program planning and coordination is possible with the current fragmentation of programs across different divisions. Ward 10, the largest treatment program for alcohol abuse in the state, is now effectively separated from the Bureau of Alcohol and Drug Abuse.

RECOMMENDATION 49: *Create a comprehensive alcoholism treatment program for the Las Vegas area.* Although a number of new or expanded programs are needed to fill gaps in the alcoholism treatment system throughout the state, the most pressing needs are undoubtedly in the Las Vegas area. Federal funds may be available to help fund such a program. The following services should be included: a nonmedical detoxification unit and holding center that can handle up to 10 clients; a short-term (e.g., 30-day) full inpatient treatment facility with perhaps 20 to 40 beds (similar to the NMHI Ward 10 program and accessible to those who cannot afford private treatment); rehabilitation or halfway houses for longer-term recovery with at least 20 to 40 beds; and a full range of outpatient services including individual and group therapy and antabuse treatment. Some of these services might be arranged by expanding or working with existing public or private facilities.

RECOMMENDATION 50: *Provide both drug and alcohol detoxification services throughout the state.* The present lack of this essential service is a major deficiency in the present service system. The 1975 Nevada State Plan for Prevention, Treatment and Rehabilitation of Substance Abuse does propose a realistic plan for detoxification services in Washoe County, but there is a lack of similarly detailed planning in the report for Clark County—which contains nearly two-thirds of the state's alcoholics.

RECOMMENDATION 51: *Establish a few small halfway or live-in rehabilitation houses for alcohol and drug abusers throughout rural Nevada, with provisions for outpatient services at those same facilities.* Rural Nevada is currently lacking in alcohol and drug abuse treatment programs and hence very few of the alcohol and drug abusers in rural Nevada who need service are being served now. Full inpatient

treatment programs are probably not practical in rural Nevada because of sparse populations, difficulty in obtaining qualified staff, and hence the high cost per person served; full inpatient services can probably be more adequately provided to rural alcohol and drug abusers through short-term residence in Reno (NMHI) or the Las Vegas alcohol abuse treatment center we recommended above. However, it does appear feasible and desirable to provide the less intensive live-in rehabilitation house and outpatient services in small programs directly in the larger rural communities. That is, some of larger rural communities appear to have sufficient numbers of people needing halfway or rehabilitation house and outpatient treatment so that small programs in those communities can be fully utilized and be economically feasible.

RECOMMENDATION 52: *Create a short-term, professionally staffed, full inpatient treatment program for drug abusers in Nevada, analogous to the NMHI "Ward 10" program designed primarily for alcohol abusers. This would fill a notable major gap in the service system.*

Another important issue in drug abuse treatment is the existing delivery system in the Las Vegas area. Before any other new expansion is contemplated (other than detoxification), there must be a careful analysis of the reasons for underutilization of some existing facilities (those reasons do not appear to include lack of need for the services) and a determination of the reasons for controversy over alleged drug use in some halfway houses in the Las Vegas area.

An alcohol and drug abuse facility plan prepared in 1974 for the Nevada Division of Rehabilitation indicated no need for additional alcohol and drug abuse treatment facilities prior to 1980 with the exception of nonhospital detoxification facilities. Although we have recommended that services be expanded, our recommendations are not necessarily inconsistent with that facility plan. The reason is that while hospital and intermediate care facilities exist in the state, as do facilities that could be used for outpatient treatment for alcohol and drug abuse, such treatment services are not now being provided in most of those existing facilities.

For a more detailed discussion of alcohol and drug abuse treatment, see Chap. 9 of the main text.

VOCATIONAL SERVICES

We estimate that at least 680 Nevadans with mental health problems, at least 660 who are mentally retarded, and at least 410 with alcohol or drug abuse problems had a need for vocational services in 1975—services such as vocational education, vocational rehabilitation, and job counseling and placement. These are conservative estimates; they do not include the many people who need only job placement assistance, and do not include youth who are not yet of age to be in their last two years of school.

About 1600 people with mental handicaps received vocational services in FY 1974 from a full-time-equivalent staff of about 120. Expenditures for those services totaled about \$2.7 million, or about \$1710 per person. We estimate that some service was provided to at least 170 Nevadans with mental health problems, at least 660 with mental retardation, to 140 with alcohol and drug abuse problems, and to 300 with some "other mental disorder" (described below). Additionally, 337 mentally

handicapped people were served by the Department of Employment Security, for whom data are not available by type of mental handicap. The programs providing vocational services discussed in this section include Vocational Rehabilitation, Community Training Centers, a Vocational Training program based at NMHI, special Vocational Education, and the Department of Employment Security. For a more detailed description and analysis of these programs and their clients, including the costs and benefits of both the programs and our recommended changes in them, refer to Chap. 11 of the main text.

The largest vocational service program is Vocational Rehabilitation, which in FY 1974 completed provision of a wide variety of services to 161 people with mental health problems, 81 people with mental retardation, 140 people with alcohol or drug abuse problems, and 296 people with some other mental disability. The clients listed as "other mental" were primarily those with disabilities the VR program calls "character, personality, or behavior disorders" (i.e., they do not fall into the other VR program categories as psychotic, neurotic, retarded, alcoholic, or drug abusing people.)

Several private community training centers receive partial funding from the Community Training Center program in the state Division of Mental Hygiene and Mental Retardation, and partial funding from the VR program. These centers provide a variety of services to preschool children and to adult developmentally disabled (primarily, mentally retarded) people for whom there is no other appropriate prevocational or vocational service program. About 180 adults were served in FY 1974.

A small Vocational Training program operated by the Division of Mental Hygiene and Mental Retardation served about 20 retarded adults in the Reno area.

The special vocational education programs in county school districts served approximately 400 mentally handicapped youth, most of whom are educable mentally retarded.

The Department of Employment Security primarily provides unemployment compensation plus job information and placement to unemployed people. The Department reported serving 79,073 people, including 337 mentally handicapped adults in FY 1974. Of these 337 people, 82 were placed in jobs, 8 were enrolled in training, 66 were provided counseling, 84 were referred to other training programs, and 30 were referred for supportive services (which includes referrals to the Bureau of Vocational Rehabilitation).

While the vocational service programs in Nevada are valuable, several problems for mentally handicapped people were identified. They include unemployment (a rate approximately twice that for people without mental handicaps); little effort to combat significant underemployment (by any vocational service program); too few people served in relation to need (with the possible exception of vocational education services for retarded youth); differential levels of service by geographic area (north-south and urban-rural differentials exist for some handicaps); differential levels of service by type of handicap (especially the extremely low emphasis on serving severely emotionally disturbed youth in the vocational education program and the low emphasis on referring for service or serving all types of mentally handicapped people by the Employment Security program); a questionable allocation of about half the limited available VR funds in FY 1974 for service to mentally handicapped people with generally less severe "other mental" disorders (i.e., people who, according to VR definition, are not primarily psychotic, neurotic, retarded, alcoholic, or

drug abusing); inadequate facilities (especially for rural Nevadans in their home counties); inadequate short-term residential facilities for rural Nevadans served in Reno and Las Vegas; inadequate referral and coordination between vocational and other types of service programs (especially between VR, Employment Security, and the schools, and between VR and some of the mental health programs); and duplication of program responsibilities (in particular, the Vocational Training program overlap with the VR and Community Training Center programs).

RECOMMENDATION 53: *Provide (1) a full comprehensive range of good-quality vocational services in the Reno and Las Vegas areas and make them available equitably to all Nevadans in need, with short-term residential arrangements in those two cities for rural Nevadans, and (2) a limited range of the more frequently needed, less specialized, and long-term vocational services in the other geographic areas. Additional vocational services are needed in rural counties as well as in Clark and Washoe Counties. While a complete range of services should be available to residents of each of the counties, and ideally one would like to locate those services close to the residents' homes, in practical terms one must establish a hierarchy of needs and recognize the quality of services that realistically can be provided in each rural county. In regard to quality of services, it is difficult to obtain specialist staff in every rural county, service specialists being in very short supply throughout Nevada. Three distinct options exist: (1) continue the present program and thus partially but inadequately meet vocational needs in rural areas; (2) undertake a very costly expansion to provide a comprehensive good-quality program of services in rural facilities; or (3) the option we recommend be adopted, offer improved long-term services locally in rural areas (e.g., education, competitive or sheltered work, and residence) but develop a cooperative arrangement to send people to the larger metropolitan areas for short-term (weeks) provision of good-quality specialized services.*

RECOMMENDATION 54: *At least double the Community Training Center minimum funding level per client for those clients receiving services but not primarily funded by some other agency. For those longer-term activities of daily living, prevocational, vocational, and sheltered-work services currently provided through the several community training centers in the state, we estimate that the costs that will be necessary to provide minimum-quality services are currently two to four times as high as the \$1200 per year minimum funding provided per client by the Community Training Center program. The state has paid a maximum of \$350 per enrollee per quarter year in large centers and \$15,000 per annum in small centers. However, in FY 1974 primary funding was provided for some 183 adult clients at these centers by the Vocational Rehabilitation program and for a few children by a county school district.*

RECOMMENDATION 55: *Eliminate the Vocational Training program and transfer its personnel and current clientele to the joint VR-WARC program. The small Vocational Training program, operated within the Division of Mental Hygiene and Mental Retardation with personnel who have no substantial prior background in vocational services, provides services in northern Nevada that overlap those provided jointly by the VR program and the Washoe Association for Retarded Citizens. Our recommended organizational change would provide more adequate supervision and direction of these staff members by professional vocational service personnel, and consolidate the overlapping programs in the bureaucracy.*

RECOMMENDATION 56: *Expand special vocational education programs to*

provide vocational services to some severely emotionally disturbed youth. The special vocational education services to mentally handicapped youth focus almost exclusively on mentally retarded youth. This differential level of service by type of handicap is hard to justify. Some emotionally disturbed children need and can benefit from special vocational education, too.

RECOMMENDATION 57: Increase the number of referrals from the Department of Employment Security to Vocational Rehabilitation of persons suspected of having mental handicaps who are not placed in jobs within a short time. The Department of Employment Security reported serving 337 mentally handicapped people among nearly 2700 handicapped people served in FY 1974; 30 or fewer were referred to the Bureau of Vocational Rehabilitation. The Employment Security program and personnel are less able to adequately serve the more severely mentally handicapped people than are the VR program and personnel.

RECOMMENDATION 58: Obtain improved program management and effectiveness information for each Nevada vocational service program. The information needed to manage some of the vocational service programs effectively is severely lacking. For the Vocational Education and Employment Security programs, for example, even the statistics on the number of mentally handicapped people served are of dubious validity. Even in the VR program, which has relatively good information, the real reasons clients are not accepted or are not rehabilitated are not clearly known partly because the information categories that can be marked on the forms do not permit the persons filling them out to fully express what they know. For example, although better reasons may be known to VR direct-service personnel, partly because of the design of the form the reasons most often marked for clients' being not accepted or not served were the clients' lack of response to or lack of acceptance of the VR program—categories of reasons that raise more questions than they answer. Finally, with the exception of the VR program, effectiveness data for vocational service programs are severely lacking. This information gathering does not require a really major or costly effort. The present effort in the VR program is more than adequate, although some of the information categories that program uses need revision so they are more illuminating (this can be done and still be consistent with federal reporting requirements).

RECOMMENDATION 59: Improve outreach and referral among vocational service programs and other nonvocational programs serving mentally handicapped people. In particular, we recommend increased numbers of referrals to Vocational Rehabilitation of mentally handicapped youth leaving school, working-age clients of the income assistance programs, and unemployed working-age clients of the Mental Health Institute, the Mental Retardation Centers, the Mental Health Centers, the Rural Clinics program, the Community Training Centers, private psychiatric service programs, and alcohol and drug abuse programs. The problem of lack of referrals between programs offering vocational services and other service programs for mentally handicapped people clearly needs attention. In all of FY 1974, for example, only 16 rehabilitated mentally disabled youth had originally been referred for vocational rehabilitation by the schools. Once service priorities are set, they can be achieved more easily if notification of the types of clients desired is clearly communicated to each referral source, and if referral of those clients is actively encouraged at the level of direct service personnel. There is a passive tendency to serve clients who present themselves or are presented to an agency, rather than to set out well-defined priority

categories of people who need service and then actively reach out to find them. One might take a dynamic and flexible approach depending on the level of vocational impairment. For example, VR might screen all mentally handicapped youth before they leave school, and automatically give mildly handicapped youth both job information and placement assistance upon leaving school; then, if they are not vocationally successful, full VR services could be given. Severely handicapped youth could be automatically offered full VR services beginning well before their scheduled departure from school (which is permissible under federal regulations). Whatever the priorities assigned, the program will come closer to meeting its goals with its available resources if effort is concentrated on finding, accepting, and serving clients in priority categories. We discussed referrals from the Department of Employment Security in an earlier recommendation.

RECOMMENDATION 60: Either expand the VR program to serve more of the severely mentally handicapped people in need, or restructure FY 1974 priorities to shift the VR caseload from emphasizing the generally less severe "other mental" handicaps toward emphasizing more severe mental handicaps without increasing the total budget. The VR program is not now serving all those in need because of mental health problems, mental retardation, and alcohol or drug abuse. This program improves the quality of life of mentally handicapped people by increasing their ability to function independently, to obtain employment, and to work at higher-quality employment. It also appears to yield economic benefits to taxpayers who are paying for the vocational services to mentally handicapped people (reduced service costs later in the mentally handicapped person's life, reduced welfare, and increased taxes paid by the mentally handicapped people) that exceed the costs of the program. The benefits to society as a whole are even larger than they are for taxpayers. (By "society," we mean all nonhandicapped and handicapped Nevadans considered as a group, including both the mentally handicapped people being served and the taxpayers who are paying for the service.) Even with assumptions designed to subject the program to a difficult test, the economic benefits exceed costs to society as a whole and to the Nevada taxpaying population for every one of the prevalent types of mental handicaps that we considered (see Chap. 11 of the main text for the detailed cost/benefit analysis). The Nevada Bureau of Vocational Rehabilitation must set its own priorities subject to federal funding guidelines, but we question whether placing highest priority on people with psychoneurotic or "other mental disorders" (as evidenced by their being the two largest categories in FY 1974 in terms of numbers of clients accepted and average cost of services per rehabilitant) is consistent with current federal guidelines giving priority to more severely handicapped people. In fact, half of all VR case expenditures on mentally disabled individuals whose cases were closed in FY 1974 went for persons in the nebulous category "other mental disability"—people who were not disabled by alcoholism, drug abuse, mental retardation, psychosis, neurosis, epilepsy, cerebral palsy, Parkinson's disease, or stroke according to VR definitions. We do not doubt that people with "other mental disorders of character, personality, or behavior" need and deserve service, but the Division of Rehabilitation may wish to concentrate its limited resources more heavily on more severe mental disorders, in line with current federal guidelines. The quality of life benefits of successfully serving more severely handicapped people can be substantial, and our detailed analysis indicates such service can be justified in an economic benefit/cost sense for all but the most severely

handicapped people. Our analysis in Chap. 11 suggests that benefits in relation to costs may actually rise with the severity of handicap and hence with the initial vocational skill deficit of the person (up to a point in severity where preparation for any job is extremely difficult). In a February 24, 1976, letter to The Rand Corporation, the Administrator of the Nevada Division of Rehabilitation indicated that priorities had been shifted toward serving more severely handicapped people. His Division's quantitative analysis of data from FY 1975 and the first half of FY 1976, when made available to the public, will allow assessment of the degree to which this shift in priorities has occurred.

For a more detailed discussion of vocational service programs and cost estimates for the above recommendations, see Chap. 11 of the main text.

MEDICAL SERVICES

Nevada's medical service programs for mentally handicapped people can affect their lives importantly in two ways: by providing treatment for the physical health needs of people who have mental health, mental retardation, or alcohol or drug abuse problems, and by providing payments for both physical and mental health services. In addition to medical personnel and facilities, programs providing medical treatment or payment include Medicare, a federal program; Medicaid (State Aid to the Medically Indigent in Nevada), and the Crippled Children's Services program, both joint state-federal funded programs; private insurance; and the privately sponsored Easter Seal Treatment Centers. Refer to Chap. 12 of the main text for details of those programs.

Private sector expenditures for medical care are not known, nor are the fractions of public medical expenditures devoted to mental health services and other medical care to Nevadans with problems of mental health, mental retardation, or alcohol or drug abuse. Program records typically are not kept in such a way as to enable the identification of, for example, a mentally retarded person being served. The only funds we can specifically identify as going for service to clients with mental problems are about \$282,000 in Medicaid funds for mental health services (identifiable because they went to mental health service personnel), and about \$75,000 in Easter Seal Treatment Center funds for mentally retarded clients. Obviously, more money than that went for people with mental problems, but we can only estimate the total. One might assume for lack of better data, for example, that the fraction of Medicaid and Medicare recipients who are mentally handicapped is the same as the fraction in the total Nevada population, and that average expenditures for a mentally handicapped client are about the same as for all other types of clients. Under those assumptions, the programs annually spend about \$1 million for people with mental health problems, \$1 million for mentally retarded people, and \$4 million for alcohol and drug abusers. We caution that these are only order of magnitude estimates based on rather tenuous assumptions made in the absence of better information.

Of the 27 Nevada hospitals, 12 offer mental health services, and 7 of those are on an emergency or partial hospitalization basis only. Outside of Las Vegas and Reno, only emergency mental health services are available, and then only at a few of the hospitals. Other medically related facilities include 18 facilities that provide continuous skilled nursing service, under medical direction, to convalescent patients

not in an acute episode of illness, and 9 intermediate care facilities that provide personal and health-care supervision for people who do not have illnesses, diseases, injuries, or other conditions that would require the degree of care and treatment that a hospital or skilled nursing facility is designed to provide. Only 12 of the 17 Nevada counties have skilled nursing facilities, and only 4 have intermediate care facilities. Apart from geographic considerations of availability of services, several people we interviewed alleged that the operators of some of these facilities find ways in practice of denying admission to mentally handicapped clients. Consequently, even where a facility exists, the services may not be accessible to mentally handicapped people.

Currently, people in Nevada have three recourses in paying for mental health services, and for medical services for all types of mentally handicapped people: (1) privately financed care for those who can afford it or who have health insurance that covers needed services; (2) programs that receive payment from public funds, such as Medicaid, Medicare, and Crippled Children's Services for low-income people who cannot afford good care, and for others who qualify; and (3) publicly financed direct service programs (sometimes with charges to families of clients who can afford it), such as the Mental Health Centers and Mental Retardation Centers. On the whole, this three-part system can be readily defended, but certain aspects of the way it has been implemented need improvement.

RECOMMENDATION 61: *Conduct a study of the effects of requiring a mandatory minimum level of coverage for mental health and mental retardation services in every private health insurance policy.* Private health insurance often either excludes mental health coverage or offers more limited coverage for mental health than for physical health problems. The 1975 session of the Nevada Legislature extended coverage of alcohol and drug abuse treatment by making it mandatory for private health insurance to provide at least a specified minimum amount of coverage for alcohol and drug abuse treatment. Potential effects of requiring such mental health and mental retardation service coverage include somewhat higher insurance costs, some decrease in the number of people purchasing health insurance because of the higher cost, increased quality-of-life benefits resulting from the increased provision of needed mental health and mental retardation services, and decreased government expenditures for services that are newly covered by private insurance. Before implementing a mandatory coverage requirement, those potential effects require careful examination as a function of the different minimum levels of mandatory coverage being considered and the types of mental disorders and services to be covered.

With respect to publicly financed health insurance programs, the nonwelfare poor population (those who are medically but not categorically needy and hence not eligible for income assistance) are in worse shape with respect to financial access to medical services than are those who can afford private care and those who are on income assistance and hence eligible for Medicaid. County welfare offices sometimes meet the medical needs of the nonwelfare poor, but exclude most mental health needs because of strained county resources. To remedy this situation, the recent Nevada legislative subcommittee on the study of the consolidation of state and local welfare programs has recommended that "... the legislature take action in 1975 to expand the SAMI (Medicaid) program to include the group known as the 'medically needy.'" If SAMI were expanded to meet the federal definition of "medically needy,"

financial eligibility would be limited to those having an income below 133-1/3 percent of the Aid to Dependent Children (ADC) grant level, after deducting medical expenses. That expansion would not necessarily include everyone who now receives county medical assistance. If the expansion were authorized, however, the state could obtain 50 percent federal matching funds.

Concerning ADC, yet another point bears consideration. As determined by the State Welfare Board, ADC payments are currently 70 percent of the full standard of need in Nevada. Anyone earning between 70 percent of this need and full standard (i.e., earning between \$230 and \$329 a month for a family of four) is deprived not only of income assistance but of Medicaid benefits.

RECOMMENDATION 62: *Supplement state monies by billing private and public health insurance programs to the maximum extent feasible to pay for state-operated direct service programs for mentally handicapped Nevadans.* With respect to publicly operated direct service programs, such as the state mental health centers and mental retardation centers, neither public nor private health insurance programs have been fully tapped in the past to pay for those direct services. By billing for service to those persons who have a means to pay (e.g., those on Medicaid or with private insurance), state-operated program monies will be supplemented, allowing for provision of more services. Personnel of the Nevada Division of Mental Hygiene and Mental Retardation have taken steps in that direction recently and we endorse their efforts. It does not make good fiscal sense from the viewpoint of the state as a whole to spend a dollar for service through the budget of the Division of Mental Hygiene and Mental Retardation, when the same service can be funded through the Medicaid budget of the Nevada Welfare Division at a cost of 50 cents to Nevada and 50 cents to the Federal Government.

We note that the Medicaid program does not provide the same coverage for all age groups in the mentally handicapped population. One effort to modify this differential coverage is embodied in the federal Social Security Amendments of 1972 (P.L. 92-603), which authorize matching federal funds for care in psychiatric hospitals for Medicaid beneficiaries under 21 years of age, if certain requirements for patient evaluation are met. Nevada might consider exercising its option of matching the 50-percent federal contribution in providing for the mental health needs of its youth. Currently, many youngsters in need of residential mental health care are unserved or have been made wards of the state and been sent to out-of-state institutions, with the Nevada Welfare Division bearing the total cost.

For a more detailed discussion of medical services, see Chap. 12 of the main text.

RESIDENTIAL LIVING

Meeting the diverse needs of mentally handicapped people requires a range of residential programs suited to the various levels of individual functioning and service needs. These programs vary from full inpatient care facilities for people who have acute mental health problems or who are nonambulatory and profoundly mentally retarded, through less service-intensive intermediate care facilities, through semi-independent residential living programs that offer minimal supervision and assistance.

Earlier we discussed mental health, mental retardation, and alcohol and drug abuse residential treatment programs intended to provide more than supervised

residential living. This section focuses on programs that provide supervised residential living for people who are unable to live with their own families or to live independently in the community; these programs are not intended to and do not provide any other substantial mental health, mental retardation, or alcohol or drug abuse services. For a more detailed discussion of residential living programs, see Chap. 13 of the main text.

Nevada's supervised residential living programs include foster homes for children, special foster homes called developmental homes for retarded children and young adults, adult group care and family care facilities, sheltered living apartments, the state Children's Homes, the state juvenile Training Centers, and the federal Stewart School for Indian children and youth. The latter three types of facilities have significant numbers of mentally impaired youth as residents, but are included in this discussion of supervised residential living programs because they provide no substantial mental health, mental retardation, or alcohol or drug abuse services.

Data are not available on exactly how many mentally handicapped people are in some of these facilities, but adding the numbers for the facilities on which some information is available yields an estimate of at least 290 mentally handicapped residents, for whom the expenditures for supervised residential living were at least \$620,000 in 1974. Those numbers do not include estimates for nonwelfare clients of adult group care and family care facilities, or for residents of the state training centers or the Stewart School.

RECOMMENDATION 63: *At least double the number of people served by the developmental home and sheltered living apartment programs.* The developmental homes and sheltered living apartments, which permit mentally retarded residents to live in sheltered foster-home or semi-independent living situations in the private residential communities, are for those people who are not yet capable of fully independent living, but do not need the much more dependent and costly residential care and treatment programs provided by the Mental Retardation Centers and the Nevada Mental Health Institute. The major problem with these programs is their tiny size; only 30 people were served in developmental homes and only 27 in sheltered living apartments in the entire state in late 1974. The type of people now in these programs typically were served previously in the more institutionalized and much more expensive residential care programs, or were not served at all by the mental retardation programs. Based on information gathered in our interviews, it appears that at least twice as many placements into these sheltered living programs could be made if they had the capacity. As more mentally retarded people with functional abilities appropriate to these programs are identified, and as the skills of people with lesser functional abilities are improved so they can be moved out of a more restrictive environment such as NMHI or one of the mental retardation centers, it is possible that the program could more than double in size. Creating more of these sheltered community living facilities would facilitate serving more people "in the least restrictive environment possible," which is one aspect of the state goal of the Nevada Division of Mental Hygiene and Mental Retardation (see Chap. 1).

RECOMMENDATION 64: *Establish facility and personnel standards and licensing specifically for private developmental homes and sheltered living apartments for retarded people, and require that staff members receive specified levels of training.* While these programs are good in theory, they can be subverted by poor implementa-

tion. We see potential problems in implementation in at least three areas that presently are handled on an ad hoc basis: facility and personnel standards for the homes and apartments; training of the staff; and supervision of the staff.

RECOMMENDATION 65: *Assign responsibility for all supervision of mentally retarded people living in private developmental homes in the community to the mental retardation centers, rather than having it shared by the centers and the Nevada Mental Health Institute. To help ensure the necessary continuing supervision of staff of these sheltered living facilities, to simplify the bureaucracy, to help the developmental homes to function in a coordinated manner, to facilitate serving those most in need first, and to provide the most efficient and effective support for the operators living in or near the developmental homes, it would appear that undivided responsibility for this program would be an improvement over the present situation, in which both the centers and the Institute are creating and monitoring developmental homes. To supervise rural county developmental homes, the mental retardation centers might contract with a local rural special education teacher of retarded children. The mental retardation centers, rather than NMHI, should be given this responsibility since personnel of the centers are located in both Reno and Las Vegas, and those personnel are more skilled in working with retarded people functioning at the level where they are candidates for developmental home placement.*

RECOMMENDATION 66: *Establish special minimum standards and supervision for foster homes and adult group care and family care facilities that provide supervised residential living for people with mental health disorders, mental retardation, and alcohol or drug abuse problems. While regular foster homes and adult group care and family care facilities presently are outside the domain of control of the mental health, mental retardation, and alcohol and drug abuse service system, it could only improve matters if those facilities that provide supervised residential living for significant numbers of people with these handicaps were subject to a few minimum facility standards and personnel selection and training standards, and received some supervision by state mental health, mental retardation, and alcohol and drug abuse personnel. These quality controls would help ensure supervised residential living of at least minimal quality for mentally handicapped people. Personnel with special expertise in serving mentally handicapped people should provide the supervision, just as the Mental Retardation Centers now do for the developmental homes. We caution that the purpose is to ensure at least minimally acceptable living conditions; care must be taken to establish reasonable standards so as not to cause existing residential living facilities simply to reject all mentally handicapped applicants because the standards are viewed as too stringent.*

RECOMMENDATION 67: *Refer each mentally handicapped foster child to the Division of Mental Hygiene and Mental Retardation or to a Division of Health Special Children's Clinic for evaluation, followed by appropriate service by both these Divisions and the local special education program if the presence of a mental disorder requiring services is confirmed. Of the children placed in foster homes by the Nevada Welfare Division, social workers suspect that more than one-third have mental problems. The Welfare Division has set up 15 specialized foster homes for some of these children.*

The Nevada Youth Services Agency facilities and related programs providing supervised residential living for children in the two state children's homes, the two

state Training Centers, the Home of the Good Shepherd, and the Spring Mountain Youth Camp were not established to serve as mental retardation and mental health treatment centers. Many of the children receiving residential care in those facilities are emotionally disturbed, however, and some are mentally retarded. Some provision should be made to see that the mental health and mental retardation service system serves those children while they are in supervised residential care programs of the Youth Services Agency. There appear to be several reasons for the lack of delivery of mental health and mental retardation services to residents of those facilities: the facilities either have no mental health and mental retardation staff or do not have sufficient qualified staff; there appears to be considerable "buck-passing" on the part of other mental programs; and the capacity of other mental service programs in Caliente, Carson City, Elko, and Boulder City, where the four primary youth facilities are located, is not high. Most certainly, the rural locations of the training centers have strongly affected the type of program they have been able to offer. Rurality denies them easy access to the specialized personnel, programs, and skills that are much more readily available in the urban centers' mental programs. Their remoteness also has made it difficult to recruit qualified staff. Finally, the present fragmented service system lacks coordination in assuring that all different types of these children's needs are met.

RECOMMENDATION 68: *Provide a professional psychological screening for all residents and referrals for residential care at the two Nevada Children's Homes and the two state training centers to identify potential mental health and mental retardation problems; once mentally handicapped youth have been identified at these state facilities, the Division of Mental Hygiene and Mental Retardation should be required to provide them with the appropriate level of services ranging from full residential treatment to day treatment to outpatient treatment. The primary burden for mental health service could be given to the Rural Clinics outpatient mental health program, which in 1974 did not serve most children from these facilities. However, before the Rural Clinic's program could adequately carry this additional service burden, it would require considerable improvement such as that which we recommended earlier in this chapter, since the Rural Clinics program is now only an embryonic program with major deficiencies. If the Rural Clinics program is not improved, some other mechanism for serving these mentally handicapped youth should be developed.*

For a more detailed discussion of residential living programs, see Chap. 13 of the main text.

INCOME ASSISTANCE

Direct income assistance is available from the following sources in Nevada: federally funded Social Security Disability Insurance (SSDI), joint state and federally funded Supplemental Security Income (SSI), joint state and federally funded Aid to Dependent Children (ADC), and county funded General Assistance (GA). See Chap. 14 of the main text for more detailed discussions of these programs than are provided below.

Only in the SSDI and SSI programs can a mentally handicapping condition be a basis for receiving direct financial aid. The Nevada Welfare Division administers ADC, Medicaid, and social services for aged, blind, and disabled people who receive

their income assistance checks directly from the Social Security Administration under the SSI program. County General Assistance provides income assistance for certain needy persons excluded from federal and state aid because they are unable to meet all eligibility requirements. This group includes persons who (1) are awaiting completion of processing of their SSI applications; (2) need emergency help; (3) are members of intact families (both parents in the home); (4) are temporarily unable to work but not technically disabled under SSI and SSDI regulations; and (5) possess income and/or resources above the eligibility restrictions of other income assistance programs. Both the state- and county-operated programs (ADC and GA, respectively) provide income maintenance to a defined population of financially needy people, some of whom also may happen to have mental handicaps.

At least 1500 mentally handicapped Nevadans received income assistance, which amounted to at least \$2 million in 1974. The estimated number served and expenditures by program were at least \$1.1 million and 450 people by SSDI; \$550,000 and 350 people by SSI; and \$400,000 and 740 people by ADC. Data were not available on GA expenditures for mentally handicapped people. Data are not available to break down those totals meaningfully by type of mental handicap for any of the four programs.

RECOMMENDATION 69: Identify each mentally handicapped person receiving financial assistance, refer him or her to other appropriate service programs (or to the Direction Centers we recommended above), and maintain much more complete program planning data. Without accurately knowing both the numbers of mentally handicapped persons served and the nature of their disabilities, there is no adequate way to plan and evaluate the system. The collection and assessment of these types of data would provide the necessary feedback to evaluate the present system, help assess its effectiveness, and meet those service needs exposed. Without adequate information in a usable format, it is not possible to ensure the provision of other needed nonfinancial assistance services. The income assistance rolls are an excellent potential source of referrals for other programs; it is a source that has not been fully tapped, with the possible exception of referrals of SSI applicants for vocational rehabilitation.

RECOMMENDATION 70: Any mentally handicapped ADC recipients who are also eligible for SSI should be transferred to the higher-paying (and primarily federally financed) SSI program. This would not only provide a more nearly adequate income for the mentally handicapped people involved, but would do so at less cost to the state (although at more cost to the Federal Government). The improved screening recommended above would facilitate this.

RECOMMENDATION 71: Supplement the federal SSI payments to mentally disabled people with state funds to provide a more nearly adequate level of income assistance. The current SSI maximum payment schedule runs below that of the federal poverty level. The Office of Economic Opportunity's poverty level (as of May 22, 1974) is \$2330 a year for one person, and the Bureau of the Census uses a poverty level of \$2396 per year (as of 1973) for a nonfarm male individual under age 65 living alone. However, SSI payments for a disabled person living independently were a maximum of \$1890 in July 1975; an individual's other sources of direct or indirect income may result in an actual payment below the maximum allowable. While nonfinancial assistance is also provided to mentally handicapped people on financial assistance programs (see Chaps. 4 to 13 of the main text for discussions of those other

services), most basic needs, such as for housing, utilities, and clothing, are met through the mechanism of direct cash transfers. In order for income assistance to continue to fulfill the function it was designed for, the state supplementary figure should periodically make allowances for inflation. We note that the state currently provides a supplement to the federal SSI payment for other categories of SSI recipients for whom the cost of meeting basic living needs is not clearly higher than it is for mentally handicapped Nevadans.

For a more detailed discussion of income assistance, see Chap. 14 of the main text.

PRIORITIES ON RECOMMENDATIONS

We have developed 71 recommendations for improving services to people in Nevada with mental health disorders, mental retardation, and alcohol and drug abuse problems. The choice by Nevadans on which recommendations, if any, to implement depends on the goal chosen and on the level of effort the government and other Nevada organizations are willing to make in improving services. The official state goal for the Nevada Division of Mental Hygiene and Mental Retardation with respect to delivery of services is to "strengthen the delivery system toward a full continuum of mental health and mental retardation services in the least restrictive environment possible, to ensure that needed services are available to all citizens, regardless of age, location, race, sex, creed, or income."⁵ (See Chap. 1.) In light of this state goal, Nevada officials can choose to make different levels of effort. We discuss three possible levels of effort below, and have grouped our recommendations according to those levels of effort: slight or no change in level of effort; modest change in the current effort; and the substantial change in level of effort required to meet the state goal. If Nevada officials choose not to make the substantial change in level of effort required to achieve the state goal, then not all 71 of our recommendations can be implemented and priorities must be set on those recommendations. In that case, Nevada should focus the limited available resources on the most important recommendations, rather than attempt to do everything and perhaps end up doing very few things adequately. The 11 different dimensions presented in Chap. 1 for assessing service system performance in relation to system goals are useful in setting priorities, since they represent different types of costs and effects of recommendations that should be considered in setting priorities. Recall that those dimensions were concerned with such factors as costs, availability of a full range of needed services, coordination of services, the quality of available services, sufficiency of service capacity in relation to need, equity of service distribution, future economic effects of service, and effects on the quality of life of the mentally handicapped person. Setting priorities would be easy if progress toward the state goal could be measured exclusively on one dimension for every recommendation. Unfortunately, the costs and effects of recommendations for improvement in the mental health and mental retardation service system must be measured on several different dimensions. And with the data available, it often is possible to know only the qualitative direction, not the quantitative amount, of the changes in the costs and effects on

⁵ Office of the Governor, *State Goals, State of Nevada*, Carson City, Nevada, March 1, 1974.

various dimensions. Consequently, setting priorities on recommendations such as ours necessarily must be a matter of judgment about the magnitude and nature of the costs and effects of the different recommendations, and a matter of judgment about tradeoffs among the different types of costs and effects.

In setting priorities, we are suggesting that certain of our 71 recommendations be implemented before others. In selecting those that we suggest be given priority and implemented if Nevada officials desire to make only a slight or no increase in the level of effort, we have stressed low-cost recommendations. In selecting those that we suggest be given priority and implemented if Nevada officials desire to make a modest increase in the level of effort, we have stressed recommendations aimed at reducing the greatest gaps in the range of needed services, the greatest deficiencies in service capacity in relation to need, and the most serious deficiencies in the quality of services that now are available. Of course, the use of different goals and criteria may result in different priorities from those we suggest below.

In our judgment, the types of recommendations we suggest be implemented at each level would contribute most toward meeting the state goal for the specified level of effort. Our recommendations are summarized in Table 2.1, grouped by type of service and by three different levels of effort government officials may choose to make to remedy the problems. The number beside the summary recommendation in the table indicates the numerical order in which the complete detailed recommendations were presented earlier in this chapter; it does not indicate priority.

The cost estimates presented later in this section are for the increase in annual expenditures required by the recommendations. The estimates were developed by using expenditure data from currently operating programs and using other information from Chaps. 4 to 14 of the main text. Each recommendation was costed in arriving at the total estimates, which we are confident are of the correct order of magnitude of the annual expenditure increase required. Extremely detailed cost analyses were not made and presented in this report, however. The actual annual cost increase will depend on exactly how Nevadans decide to implement the recommendations.

Status Quo Level of Effort

The status quo level of effort, involving slight or no increase in total resources for services, might be chosen by those who are more interested in holding the line on current expenditures than in resolving the major service problems that exist. Such a choice is understandable, but Nevada clearly is not achieving and cannot achieve its state goal with respect to delivery of services to mentally handicapped people if there is little or no change in the current level of effort. Furthermore, the wisdom of economizing on current service expenditures for people with mental handicaps can be challenged on humanitarian grounds for all services, and on long-term economic grounds for some types of services (e.g., prevention of certain types of mental retardation, and vocational rehabilitation). An implicit tradeoff is between the cost of current services and the implicit cost associated with the diminished quality of life of the person who is unserved or inadequately served.

Even if there is to be only a slight increase or no increase in the level of effort, by which we mean a 5 percent or less increase in annual expenditures, many of our recommendations can be implemented, as shown in Table 2.1. Our several recom-

recommendations on management practices and organizational structure, for example, can be implemented at little or no additional cost but can enhance the control, coordination, and performance of the service system. Better program management and service effectiveness information can be obtained. Without increasing the overall level of resources expended, Nevada can shift the client focus in certain programs, as outlined in two of our low-cost recommendations. As to priorities among different types of mentally handicapped people, this is a matter for the judgment of state officials and is beyond the province of this study. If state officials choose to maintain the status quo level of effort, the question of the relative emphasis to place on service to people with mental health disorders, mental retardation, or problems of alcohol or drug abuse—that is, who will not be served—is not an easy or comfortable one to answer.

Each of the recommendations shown in the "slight or no increase in the level of effort" column of Table 2.1 was placed there because of its low cost—an estimated increase in annual expenditures in the \$0 to \$100,000 range—with one exception. Our recommendation for establishment of two Regional Direction Centers would cost approximately \$500,000 a year. Regional Direction Centers are included because they are a key element in a set of recommendations primarily aimed at improving the management, coordination, and information in the service system. The presence of Regional Direction Centers would enhance the effectiveness of the other recommendations in that column also aimed at improvement in management, coordination, and information. The total estimated increase in annual expenditures required to implement all recommendations in the "slight or no increase in the level of effort" column is \$1.8 million.

To begin to resolve most of the major problems we noted, however, expenditures and staff will have to expand. The state goal for the mental health and mental retardation service delivery system cannot be achieved with only a slight or no increase in the level of effort.

Beginning to Face the Facts

State officials might also choose to make some modest increase above the current level of effort in recognition of the massive problems that still prevail with Nevada's mental health and mental retardation service system. By "modest," we mean up to a 50 percent increase in annual expenditures above the FY 1974 level of effort.

If the level of effort is to be increased, we would add certain priority types of recommendations to those already cited for the "slight or no increase in level of effort" case. Recommendations listed in the "modest increase in level of effort" column of Table 2.1 are those which we feel address the greatest gaps in the range of needed services, the greatest deficiencies in service capacity in relation to need, and the most serious deficiencies in the quality of services that now are provided.

For people with mental health disorders, we would assign priority to our recommendations in the areas of: identifying people in need of service by screening high-risk groups and screening each schoolchild once; expanding special education to serve all seriously emotionally disturbed children the law now says must be served; restructuring, upgrading, and expanding rural mental health services; providing improved follow-up treatment of people released from residential mental health programs; providing intermediate levels of mental health services to those needing

Table 2.1
SUMMARY OF AREAS OF RECOMMENDATIONS AND COSTS, BY DESIRED CHANGE
IN LEVEL OF EFFORT
(Fiscal Year 1974 expenditures = \$35 million)

Suggested Priority Areas of Recommendations by Desired Change in Level of Effort			
	<i>Slight or No Change</i>	<i>Modest Increase</i>	<i>Meeting All the Needs</i>
Service Need	Estimated Annual cost increase of \$1.8 million (5 percent)	Estimated annual cost increase of \$16 million (46 percent); adopt all "slight or no change in desired level of effort" recommendations in each service need area, plus those listed below	Estimated annual cost increase of \$27 million (77 percent); adopt all "slight or no change" and "modest increases in desired level of effort" recommendations in each service need area, plus those listed below
<i>Direction</i>	1. Establish Regional Direction Centers 2. Strengthen state advisory boards		
<i>Prevention</i>	6. Assign specific responsibility for prevention of mental retardation		3. Expand genetic counseling with respect to mental retardation. 4. Ensure provision of immunizations, Rh desensitization and PKU screening 5. Expand family planning services, and create a high-risk registry for newborns
<i>Identification</i>		10. Provide behavioral and psychological screening once for each young school child 11. Screen high-risk groups for mental health disorders	7. Establish health and developmental screening of new school enrollees 8. Improve Medicaid early screening and follow-up 9. Expand Special Children's Clinics' mental retardation diagnostic services
<i>Special Education and Training</i>	13. Allocate special education funds by specific handicap and enforce current standards 16. Revise preschool program focus in Community Training Centers 17. Revise preschool program focus in Special Children's Clinics. 18. Increase referrals from schools to other service agencies 19. Obtain better information on special education and training programs	12. Increase the number of special education units funded 15. Provide appropriate special education and training to mentally retarded Nevada Mental Health Institute (NMHI) residents	14. Increase state special education technical advisory staff and provide technical assistance to rural counties
<i>Mental Health Services</i>	20. Fill authorized professional staff positions at the Las Vegas Mental Health Center 23. Increase Rural Clinics efforts for people with substantial mental health disorders 26. Revise the Las Vegas Children's Behavioral Services staff and the service focus 29. Provide specified staff mix and client focus in Children's Behavioral Services residential programs 34. Restrict use of Mentally Disordered Offender Facility to prisoners 36. Provide a physically secure mental health unit at NMHI 37. Revise the role of NMHI to fulfill four specified functions 38. Obtain better information on mental health programs	22. Upgrade rural mental health staff, and add part-time traveling service teams based at NMHI 28. Establish an upgraded mental health technician personnel classification and a university-based training program 31. Improve follow-up treatment of people released from residential mental health programs 32. Create programs to provide an intermediate level of mental health services over an extended time period for children and adults	21. Provide 24-hours-a-day emergency crisis intervention service in mental health centers and Rural Clinics 24. Establish a second community mental health center in Clark County 25. Expand the Reno Mental Health Center into a full community mental health center 27. Provide mental health services to mentally retarded people if needed. 30. Correct major deficiencies in mental health services noted in the NMHI accreditation report 33. Establish halfway houses for people with mental health disorders 35. Provide specified mental health services in Nevada State Prison

Table 2.1 (Continued)

Suggested Priority Areas of Recommendations by Desired Change in Level of Effort			
	<i>Slight or No Change</i>	<i>Modest Increase</i>	<i>Meeting All the Needs</i>
<i>Mental Retardation Services</i>	40. Do not reduce existing NMHI mental retardation staff size when Desert Developmental Center opens 42. Consolidate state mental retardation program control by removing control of mental retardation services from the NMHI Director 44. Expand special education and training, as appropriate, for Eagle Valley Children's Home residents 46. Obtain better information on mental retardation programs	39. Improve the NMHI mental retardation program to meet JCAH accreditation standards 41. Provide the equivalent of the Desert Developmental Center services to northern Nevadans, but defer major facility construction 43. Improve training of state "Technicians" serving mentally retarded people 45. Provide special services to mentally retarded prisoners	
<i>Alcohol and Drug Abuse Services</i>	47. Obtain better information on alcohol and drug abuse programs and prevalence rates 48. Streamline the organizational structure for alcohol and drug abuse programs	49. Create a comprehensive alcohol abuse treatment program for the Las Vegas area 50. Provide alcohol and drug detoxification services throughout Nevada 51. Establish rehabilitation houses for rural alcohol and drug abusers 52. Establish a full inpatient treatment program for drug abusers	
<i>Vocational Services</i>	53. Provide specified general vocational services in rural areas, with short-term more specialized services in urban areas for rural residents 55. Consolidate the Vocational Training program with specified vocational program 57. Increase referrals from Employment Security to the Vocational Rehabilitation program 58. Obtain better information on vocational service programs 59. Increase referrals from nonvocational to vocational service programs		54. Double the Community Training Center minimum funding per client 56. Provide vocational education for emotionally disturbed youth 60. Expand the Vocational Rehabilitation program or shift the caseload emphasis to serve more severely handicapped clients
<i>Medical Services</i>	61. Study the effects of mandatory mental health and mental retardation service coverage in private health insurance 62. Supplement state-operated program funds by billing private and public health insurance to extent feasible		
<i>Residential Living Services</i>	64. Establish standards for developmental homes and sheltered living apartments 65. Consolidate developmental home supervision responsibility	63. Double the size of the developmental home and sheltered apartment living programs	66. Implement standards and supervision for foster homes and Adult Group Care and Family Care Facilities serving mentally handicapped people 67. Refer mentally handicapped foster children for services as appropriate 68. Screen residents of Youth Services Agency facilities for mental handicaps, followed by services as appropriate
<i>Income Assistance</i>	70. Transfer mentally handicapped Aid to Dependent Children recipients to the Supplemental Security Income program, if they qualify		69. Identify financial assistance recipients with mental handicaps, and refer for services as appropriate 71. Provide a state supplement to the SSI payments to mentally handicapped people

them over an extended time; and substantially upgrading the skills of mental health technicians.

For mentally retarded people, we would assign priority to our recommendations in the areas of: identification of people in need of service by screening each school-child once; increasing special education resources to serve all those children the law now says must be served, and to provide appropriate special education and training to mentally retarded Nevada Mental Health Institute residents; expansion of developmental homes and sheltered apartment living opportunities in the community; providing the equivalent of the Desert Developmental Center's range and quality of services to northern Nevadans; improving the training of state "technicians" who serve mentally retarded people; providing special services to mentally retarded prisoners; and bringing the severely deficient mental retardation program at the Nevada Mental Health Institute up to accreditation standards.

For alcohol and drug abusers, we would assign priority to our recommendations in the areas of: creating drug and alcohol detoxification services statewide; creating a comprehensive alcohol abuse treatment program in the Las Vegas area; creating an inpatient drug treatment program analogous to the one existing for alcohol abuse treatment at the Nevada Mental Health Institute; and creating rehabilitation houses plus an outpatient program in rural Nevada.

We stress that, within the above lists for each type of mental handicap, we do not mean to imply relative priorities by the order in which we present areas of recommendations; and we repeat that state officials must decide on priorities among handicaps. We further note that, immediately above and in Table 2.1, we have described areas of recommendations in brief general terms; the complete recommendations were presented in earlier sections of this chapter.

Implementation of each of the recommendations cited in the "modest increase in level of effort" column of Table 2.1 would require an estimated increase in the level of annual expenditures of approximately \$16 million, or about 46 percent above the FY 1974 level of expenditures. Of all the priority recommendations, the one for increasing the number of special education units funded for mentally retarded and seriously emotionally disturbed children is the most expensive, an estimated \$5.8 million annually above FY 1974 expenditures. Our estimate of the cost of each of the other recommendations is \$1.2 million or less annually, and usually substantially less. Even if Nevada officials approve that \$16 million increase in level of effort for the priority recommendations we listed, many of our 71 recommendations, which we regard as necessary to resolve major service system problems for mentally handicapped Nevadans, would not be implemented.

Meeting All the Needs

If Nevada officials decide to make the level of effort required to meet all the needs of each different group of mentally handicapped people, then all of our recommendations should be implemented. The question is whether Nevada officials are willing to make the commitment necessary to achieve the official state goal.

We estimate that the total increase in the level of effort required to implement all 71 of our recommendations would be approximately \$27 million per year above the level of FY 1974 expenditures, depending on how state officials implemented the recommendations. This represents a 77 percent increase. One of our recommendations, for increase in the income assistance level in the Supplemental Security

Income program, will benefit both physically and mentally handicapped people; only the cost of the increase associated with the mentally handicapped population is included in the above estimate. Implementation of our recommendations is not inexpensive, but we believe it is necessary if Nevada is to achieve its official goal for the mental health and mental retardation service delivery system.

The fact remains that there are great unmet and inadequately met service needs of Nevadans with mental health disorders, mental retardation, and alcohol and drug abuse problems. It is up to Nevada to say how far it is willing to go in meeting those needs.

Chapter 3

THE MENTALLY HANDICAPPED POPULATION

In estimating the number of people needing services because of mental retardation, alcohol or drug abuse, and mental health problems, we begin with a projection and analysis of Nevada's total population today and ten years in the future. We then estimate the prevalence rates of various mental handicaps in the Nevada population; those rates, applied to the total population, yield numerical estimates of the various types of mentally handicapped people. We chose a ten-year planning horizon because many major substantive program and facility changes require five to ten years for full implementation, and hence require planning now. It is both less essential and less feasible to plan fully for more than ten years in the future, because of uncertainties concerning Nevada's population growth beyond ten years, and because it is not necessary to make immediate decisions on most program changes that would take place so far in the future. Given the uncertainties about population growth and about the fractions of the population with various mental handicaps, the best planning strategy would be to make service decisions that allow for flexibility in growth of the number of people served, and to reassess periodically the extent to which mentally handicapped people in need are known to be unserved.

In most service areas in Nevada today, current service providers know of unserved mentally handicapped people or have relatively untapped sources of referrals. Consequently, if the state decides to expand program service, it can do so in most service areas without fear that the added capacity will not be needed. The primary point is that although the projected unmet need for most service programs in Nevada is uncertain, it exceeds any expansion that appears achievable in the near future (in terms of ability to obtain funding, and ability to create and adequately staff new facilities and programs).

Concerning definitions and prevalence of different types of mental handicaps, which are covered in more detail in later sections of this chapter, our prime observations are that (1) definitions presently used in the service system often vary from agency to agency, if an agency defines mental handicaps at all;¹ (2) the stated definitions are generally subject to considerable interpretation and are almost never clear; and (3) the general unavailability of reliable data on prevalence results in divergent estimates by different sources.

From the standpoint of this study, a mentally handicapped person is broadly defined as a person with a significant mental impairment that substantially limits his or her functioning in one or more major life activities, and results in a substantial need for special services that nonhandicapped people do not require. Because this study is concerned with the policy of providing services, a handicap is defined in terms of the need for services.

The study focuses primarily on people afflicted with what are generally called problems of mental health, mental retardation, and alcohol or drug abuse. Our

¹ Definitions used by different programs are presented in the relevant subsequent chapters, where the programs are discussed in detail.

occasional use of the shorthand generic term "mental handicap" refers to people with one or more of these four problems who need service, but it in no way assumes a commonality of need for particular services by so widely diverse a group. The needs of people whose primary problems are with other types of mentally related handicaps, such as cerebral palsy, epilepsy, Parkinson's disease, and stroke, are equally important but beyond the scope of this study.

Although much has been written on the difficulties of classifying people to be served, and on the hazards of labeling, classification is useful in obtaining appropriate services for people in need, for planning and seeking support for programs, and for evaluation. Some sort of classification is unavoidable. The aim should be to retain its usefulness while striving always to minimize the sometimes negative effects of labels.²

Estimates of the number of mentally handicapped people vary widely depending on the definitions used, the data accepted, and the type of service needed. While we are not fully satisfied with the reliability of the estimates we present in this chapter, we are confident that they represent the correct order of magnitude of those people requiring at least some of the special services described in this report. We make no attempt here to settle on the "best" single definition of each handicapping condition, since we believe that a single definition of a handicap to use in determining eligibility for every type of service would be inappropriate even if it were semantically satisfying. Our objective here is to discuss some commonly used definitions.

First, handicapping conditions usually have multiple dimensions. A person may be handicapped in one dimension or type of functional capability and not in another. Ideally, from a standpoint of service policy, the definition of a particular handicap, used for establishing a client's eligibility for service, should be based on the client's need or functional capability as well as ability to benefit from the service. In short, the definition should depend on the type of service to be given. Operationally, this means that a set of definitions, not a single definition, is needed for each generic type of handicap.

Given that one wants to decide who is and who is not to be served, another problem is where to draw the line. In defining mental retardation, for example, some agencies arbitrarily set the boundary at an IQ of 70. It is not so easy to explain, however, why a child with, say, an IQ of 68 should need educational services different from those given to a child with an IQ of 72. With mental retardation, as with all other handicaps, there is a continuum in the degree of severity of the handicap; moreover, the handicap can be measured on different dimensions (e.g., IQ and several types of adaptive behavior for mentally retarded persons). One-dimensional and purely binary definitions—the person either is or is not handicapped—are blunt instruments for measuring a person's need for service.

Finally, the severity of a handicapping condition depends on the environment in which the child and later the adult finds himself or herself. That is, the need for

² The classification of people with mental retardation or mental health problems is not to be taken casually. See T. Szasz, *Law, Liberty, and Psychiatry*, The Macmillan Company, New York, 1963; O. G. Simmons, *The Mental Patient Comes Home*, John Wiley and Sons, New York, 1963; N. Hobbs, *The Futures of Children: Categories, Labels, and Their Consequences*, Jossey-Bass Publishers, San Francisco, 1975; and a host of others who have been deeply concerned with the labeling problem and its various, sometimes unpleasant, side effects. An excellent empirical case detailing the problems of public opinion on mental health is presented in: H. J. Halpert, *Public Opinions and Attitudes Toward Mental Health*, U.S. Public Health Service, Publication No. 1045, Washington, D.C., 1963.

particular services depends on the person's functional capabilities in the environment (e.g., school or work, city or country).

Because of these difficulties in developing definitions, later in this chapter we delineate our assumptions about the various types of mental handicapping conditions and their prevalence, so that those who disagree can alter our estimates to arrive at their own conclusions. Throughout this chapter we present a range of prevalence estimates for the various mental disorders; Table 3.1 summarizes the conservatively estimated *minimum* numbers of people with each type of disorder who need services. Note that at least 66,000 people needed some type of substantial services in Nevada in 1975 because of mental disorders; the minimum number in need of services will grow to about 89,000 by 1985. (Alcohol and drug abusers may outnumber people with mental health or mental retardation problems two to one, but depending on the objectives and priorities one sets, equal importance may not be assigned to serving all people in each of these different mental handicap groups.) If we were to use the top rather than the lower end of our range of estimates of prevalence for each type of disorder, the estimated *maximum* number in need of some services is about 122,000 in 1975 and 163,000 in 1985.

Table 3.1
ESTIMATED MINIMUM NUMBERS OF
MENTALLY HANDICAPPED NEVADANS,
BY TYPE OF HANDICAP

Type of Handicap	Number	
	1975	1985
Mental health problems	11,000	15,000
Mental retardation	11,000	15,000
Alcohol and drug abuse	44,000	59,000
Total	66,000	89,000

SOURCES: See text of Chap. 3.

POPULATION PROJECTIONS AND ANALYSIS

This section presents demographic projections to 1985 for the state of Nevada and its two metropolitan areas, Las Vegas and Reno. The projections and accompanying background analysis provide a basis for forecasts of the mentally handicapped population. Their applicability may be broader, however, in that the projections point up some major demographic uncertainties that condition such forecasts.

In this section, we derive our "best-estimate" projection of 759,000 for 1985; it is based on an assumed continuation of recent fertility and migration trends, and it follows the post-1970 trend in Nevada's population rather closely. Our illustrative "low" projection of approximately 689,000 differs only in its assumption about the subsequent rate of migratory growth. The migration component is the major uncertainty in projecting Nevada's growth.

It would be difficult to select an illustrative "high" projection on other than arbitrary grounds. Nevada's relatively small population and its inherent sensitivity to California's migration make the *potential* for growth very large. As an alternative, then, we explore several possible scenarios of future growth without using specific numbers. One such scenario envisions a modest economic boom in the state. Another explores the possibility that Nevada may emerge as a major national terminus for retirement migration.

In mentioning either low or high projections, there is always the danger that the forecaster will be misunderstood as flatly predicting a particular outcome or declaring it to be the limit of what can reasonably be regarded as possible. We hope to be spared such misunderstanding. Demographers themselves are aware that population forecasting has become a hazardous occupation full of unsettling surprises (as witness the sudden drop in the national fertility rate and the recent trend of migration to nonmetropolitan areas). We therefore present these alternatives to our "best-estimate" projection to create an awareness of possibilities that might otherwise be ignored.

The remainder of this section discusses details of the Nevada general population estimates. Readers more interested in definitions and in the prevalence of various types of mental handicapping conditions may wish to proceed to the next section.

Evaluation of Available Projections

In evaluating demographic projections, two yardsticks are necessary. One is *analytical* and concerns the validity of the projection model's basic assumptions. The other is *performance-related* and concerns how closely the projected trend agrees with the trend observed to date. In judging a given projection, it is necessary to ask whether certain analytical standards are met, regardless of performance to date. In choosing between two projections that are equally sound analytically, performance to date becomes a basis for choice.

In reviewing the available demographic projections to find likely candidates for use, we have focused on those published by three separate agencies: (1) the State of Nevada water planning report No. 5, prepared by Victor R. Hill, (2) the most recent published projections by the Bureau of Economic Analysis (BEA), and (3) the standard series of projections prepared by the U.S. Bureau of the Census.^{*} These projections are shown in Table 3.2, along with postcensal estimates of population through 1974.

Between 1960 and 1970, Nevada's population increased 71 percent (an average annual rate of 5.4 percent), better than five times the national rate of increase. The state's population reached 489,000 according to the 1970 Census. Since then, its average annual growth rate has slowed to 3.5 percent. About two-thirds of the decline in the annual growth rate can be attributed to a reduced net inflow of migrants; one-third is attributable to a decline in the crude birth rate. (The reader should not make too much of these estimates, however; they are rather unstable, especially the one concerning migration.)

^{*} A fourth source discussed later in this section, is the work of Dr. S. F. Chu of the University of Nevada's Bureau of Business and Economic Research. It was used to make the projections by major subregions of Nevada. One other source consulted was the National Planning Association's *Regional Demographic Projections: 1960-85*. These were judged to be too out of date.

Table 3.2

PROJECTIONS OF NEVADA'S RESIDENT POPULATION, 1975-2000,
WITH POSTCENSAL ESTIMATES TO 1974
(Numbers in thousands)

Sources and Assumptions	Projected Population					
	1975	1980	1985	1990	1995	2000
Nevada water planning report (no explicit assumptions)	620	770	931	1082	1207	1319
Bureau of Economic Analysis (fertility = 1972 level; migration = by-product of economic growth)	—	616	—	761	—	—
Bureau of the Census						
Series I-C (high fertility; continued migration)	589	693	801	903	—	—
Series III-C (high fertility; no net migration)	528	576	628	680	—	—
Series I-E (1972 fertility; continued migration)	584	673	769	836	—	—
Series III-E (1972 fertility; no net migration)	524	559	595	629	—	—

SOURCES: State Engineer's Office, State of Nevada, *Water for Nevada: Report No. 5. Forecasts for the Future—Population*, Carson City, Nevada, February 1973.

Bureau of Economic Analysis, Regional Economic Analysis Division, "State Projections of Income, Employment, and Population to 1990," *Survey of Current Business*, Vol. 54, No. 4, April 1974, pp. 19-45.

U.S. Bureau of the Census, *Current Population Reports*, Series P-25, No. 477, March 1972.

NOTE: Nevada's population in the 1970 Census was 489,000. Its estimated population in 1972 and 1974, according to the U.S. Bureau of the Census, *Current Population Reports*, Series P-25, was:

1972: 533,000 (Report No. 520, July 1974);

1974: 573,000 (Report No. 539, January 1975).

If the recent growth rate actually continued, Nevada's population should have reached 587,000 by mid-1975. Although this hypothetical target is two years beyond the latest available estimate, it provides a performance-related yardstick for appraising the above projections. There is now substantial reason to doubt the 1975 population projection of 620,000 appearing in the state water planning report (representing a 4.9 percent annual rate of increase). It appears too high when viewed against the actual 1970-1973 trend; more important, it has several limitations analytically. According to the published report, the projection lacked explicit assumptions about the demographic components (fertility, mortality, and migration) of projected change.

The BEA and Census projections, in contrast, rest on satisfactory analytical assumptions. Both assume completed cohort fertility to be 2.11 births per woman (the standard Census Series E assumption corresponding to the 1972 fertility level); they differ with respect to their assumptions about migration. The BEA projection assumes that net migration responds to changes in Nevada's income and employment (as projected by BEA using a highly disaggregated model of national, regional,

and state economic growth). But judged against the post-1970 trend, BEA's projection is proving low. For 1980, the BEA model projects a population of 616,000, or an implied ten-year increase of 127,000, between 1970 and 1980. By 1973, however, it was estimated that Nevada's population already had increased 59,000, implying a further increase (under the BEA's projection) of only 68,000 during the remaining seven years of the decade.

Of the Census Bureau's state-level projections, Series I-E is now the most reasonable, given the national fertility decline. It rests on the same fertility assumption as the BEA projection, but unlike the latter it involves no specific assumptions about the economic determination of migration. All Census Series I projections assume a continuation of 1960-1970 gross migration trends.⁴ Since there is no basis for expecting BEA's untested procedure for handling migration to be superior to the Census procedure, we must rely on performance-related criteria to choose between the two. On these grounds, Census Series I-E is preferable: its 1975 projection of 584,000 tracks closely to the observed trend through 1973 (which, were it to continue for two more years, would reach 587,000). Indeed, the expected error in the estimate of Nevada's 1973 population could easily account for the differences between these two figures.

In summary, the preferred choice for the "best-estimate" projection is Census Series I-E: its analytical assumptions are realistic in view of current fertility and apparent migration; and the population's actual rate of increase since 1970 tends to confirm their expectations. For an illustrative "low" projection, the BEA projection is our choice: it differs from Series I-E only with respect to migration, which is the critical factor of uncertainty about Nevada's demographic future. On grounds of its performance to date, the BEA projection appears to be low.

Future Growth Possibilities: Two Scenarios

In the previous section, we used demographic and performance-related criteria to select "best-estimate" and illustrative "low" projections of Nevada's future growth. When it comes to selecting a single "high" projection, other considerations complicate the choice. The state's population is very small, consisting of two medium-size metropolitan settlements—Las Vegas and Reno—with the remaining population scattered thinly about the state. Equally important, Nevada's population growth is closely linked to flows of migration to and from heavily populated California. Any shift in the numbers or destinations of migrants departing that state, although minor from a Californian vantage point, could amount to a major exogenous change from the vantage point of Nevada. The net result is that Nevada is susceptible to virtually limitless possibilities for growth over the near to intermediate term.

That point can be illustrated by examining directional migration flows between Nevada and California.⁵ Between 1965 and 1970, 110,100 migrants entered Nevada;

⁴ This assumption results in an automatic gradual moderation of the future net migration rate, for technical reasons that need not concern us here. (For details, see U.S. Bureau of the Census, *Current Population Reports*, Series P-26, No. 477, March 1972.) This moderation of net migration is a desirable characteristic of the projection. It is consistent with the idea that migration is responsive to economic and social imbalances and that migration will to a large extent tend to moderate the imbalances existing at the beginning of the projection period. This characteristic makes no allowance, of course, for a change in trend due to imbalances that may develop.

⁵ The migration flows discussed here relate to a five-year migration interval derived by comparing 1965 and 1970 places of residence. These data register only a fraction of all moves that occur. For example,

of these 43,000 (39 percent) originated in California. During the same period, 89,000 migrants left Nevada, of whom 32,600 (37 percent) went to California. Nevada therefore gained 21,100 new residents through net migration, with California contributing fully 10,400, or 49 percent.

Migrants going to Nevada represent a mere 3.2 percent of California's 1.3 million outmigrants—a minor demographic subtraction from a large population base at origin. But to Nevada's small population base (one-fortieth the size of California's), these migrants represent a sizable addition. Minor shifts in the destination choices of departing Californians, therefore, could make for extraordinary fluctuations in Nevada's net migration rate. For example, if the percentage of California's outmigrants going to Nevada rose only from 3.2 to 4.0 percent, net migration from California to Nevada would increase from +10,400 to +21,200, producing approximately a 50-percent increase in Nevada's total net immigration.

The following two scenarios elaborate on this uncertainty by considering how such shifts might come about.

Scenario 1: An Economic Boom in Nevada. Let us postulate a modest economic boom in Nevada triggered by exogenous changes. For example, Nevada might be selected as the site for a major military installation. Or, domestic tourism may expand as the cost of European travel increases. Or, price increases may revitalize the relatively dormant gold and silver mining industry. Whatever the origin of the boom, there would be little friction impeding the tendency for economic and migratory growth to reinforce each other. Since California represents a relatively unlimited labor pool on which Nevada can draw, the influx of migrants into Nevada could be prompt. Spending by new wage-earners would tend to stimulate further employment growth by increasing the demand for local goods and services, thereby drawing still more migrants to fill new jobs.⁶ Although specific magnitudes can only be guessed at, concrete examples offer some guidance. In Orlando, Florida (a metropolitan area whose 1970 population of 428,000 was comparable in size to Nevada's), growth in the recreation industry has attracted a major influx of migrants. After Disneyworld opened, Orlando's population increased 34 percent during the 1960's and an additional 20 percent between 1970 and 1973. Metropolitan Huntsville, Alabama (with a population about half that of Nevada in 1960), increased 48 percent during the 1960's, illustrating the local effects of a defense boom.

Scenario 2: Nevada as a Major Terminus of Retirement Migration. In coming years, retirement migration may be increasingly important to the growth of certain states. For one thing, there will be a gradual rise in the national percentage of the population aged 65 and over. Table 3.3 provides relevant data on this trend for the nation and for Nevada's all-important neighbor, California. Note that the percentage of elderly Californians is expected to rise from 9.16 in 1970 to 10.43 in 1990, an overall 61-percent numerical increase from 1.804 to 2.910 million.

Where this increasing number of elderly persons—especially those in California—migrate is a matter of considerable importance to Nevada. Quite possibly, the locational options of the elderly may be enlarged by new sources of income, such as

some persons move several times within a five-year period; others who migrate and then return appear as nonmigrants. Nevertheless, the five-year data employed here allow us to compare the relative magnitudes of different directional migration streams.

⁶ For supporting evidence on the self-perpetuating link between economic and migratory growth, see Peter A. Morrison, *Migration from Distressed Areas: Its Meaning for Regional Policy*, The Rand Corporation, R-1103-EDA/FP/NIH, 1973, pp. 16-18.

Table 3.3
 PROJECTED POPULATION AGED 65 AND OVER, UNITED STATES
 AND CALIFORNIA, 1975-1990
 (In percent)

Area	1970 Census	Projection			
		1975	1980	1985	1990
United States	9.77	10.36	10.73	11.00	11.26
California ^a	9.16	9.73	9.99	10.19	10.43

SOURCES: For United States: U.S. Bureau of the Census, *Current Population Reports*, Series P-25, No. 493, December 1972, and No. 511, January 1974, Census Series E projection (completed cohort fertility of 2.11 children per woman).

For California: Population Research Unit, California State Department of Finance, unpublished projections of population by age, based on Census Series D fertility assumption (completed cohort fertility of 2.50 children per woman), and annual in-migration of 150,000. (Only the Series D projection is available by age.)

^aCivilian population only.

the federal Supplemental Security Income program and other income maintenance programs likely to be enacted in coming years. Assured of a steady income regardless of where they live, many retirees may become floating consumers predisposed to migrate in highly directed ways to locales offering a favorable cost of living.

Referring again to the census migration data: 150,000 persons 65 and over migrated out of California between 1965 and 1970. While the exact percentage going to Nevada is not known, it is likely to be in the vicinity of 3.2 percent (the figure for all ages). Turning this figure around, 96.8 percent of elderly California outmigrants went somewhere other than Nevada. If only one in twenty of these outmigrants had gone to Nevada instead, total net migration (all ages) into the state of Nevada would have been approximately one-third higher. (California-Nevada net migration itself would have been 70 percent higher.)

Such a 5-percent shift in the destination preferences of the elderly is not implausible. A local escalation of living costs in major retirement areas like Florida or Arizona could divert a small fraction of the stream of retirees from California and other states to Nevada. The same might happen if large corporations developed retirement communities in Nevada modeled after places like Leisure World, California, and Sun City, Arizona.

Whatever the immediate causes of an influx of retirees, its effects would not be confined to the elderly. As Florida's experience shows, the demands for services generated by retirees create new jobs which, in turn, attract more immigrants to the state.

Projecting Age Composition

For certain of the analyses to follow in later chapters of this report, we require an age-specific population projection, which is not furnished for either the Census or BEA series we are using. Therefore, we have adapted national age-specific

projections for use in conjunction with the "best-estimate" and "low" projections. An all-purpose projection of relative age distribution has been derived and applied to both numerical projections.

Largely because of fluctuations in annual births during most of the twentieth century, population trends in most age groups have differed greatly from trends in total population. Especially noteworthy are the sustained post-World War II fertility rise and subsequent decline, which began in the mid-1960's and is still under way. The bumper crop of children in the 1950's crowded the schools in the 1960's, and are now seeking jobs and homes (but having fewer children) in the 1970's.

In addition to accounting for these national demographic impulses, which affect the population in every state, we also must allow for current and future differences between the national age distribution and that of Nevada. In 1970, with respect to the nation as a whole, Nevada's population had a surplus in the under-10 and 25-to-54 age brackets, and a deficit in the 15-to-24 and 55-and-over brackets (see Table 3.4, col. 3). These atypical features of Nevada's age distribution probably derive from the complex age-selectivity of migration; also, they may be linked to the population's distinctive racial, ethnic, and religious makeup. These differences have to be taken into account, since they could be of some consequence for future programs to serve handicapped populations of a particular age.

The projection method adopted here is premised on three assumptions: (1) completed cohort fertility will be 2.11 births per woman; (2) Nevada's population will reflect the impending national changes in age composition with equal intensity; (3)

Table 3.4
DERIVATION OF PROJECTED NEVADA AGE-DISTRIBUTION

Group	Projected Nevada Age-Distribution ^a						
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Nevada, 1970	U.S., 1970	(1) ÷ (2)	1975	1980	1985	1990
Under 5	8.97	8.39	1.07	8.39	8.86	9.27	8.80
5-9	10.36	9.71	1.07	8.67	8.07	8.43	8.88
10-14	10.14	10.16	1.00	9.38	7.81	7.19	7.58
15-19	8.22	9.42	0.87	8.52	7.85	6.48	6.02
20-24	8.00	8.39	0.95	8.32	8.93	8.14	6.80
25-29	7.67	6.72	1.14	9.22	9.54	10.18	9.37
30-34	6.98	5.63	1.24	8.00	9.63	10.25	10.58
35-39	6.42	5.47	1.17	6.21	7.22	6.58	9.20
40-44	6.36	5.82	1.09	5.67	5.61	6.30	7.56
45-49	6.31	5.96	1.06	5.84	5.18	5.08	5.76
50-54	5.73	5.40	1.06	5.83	5.42	4.75	4.71
55-59	4.84	4.88	0.99	4.91	4.96	4.55	4.36
60-64	3.66	4.23	0.87	3.76	3.83	3.82	4.55
65-69	2.62	3.34	0.78	2.80	2.86	2.89	2.92
70-74	1.69	2.75	0.61	1.67	1.76	1.78	1.82
75+	2.02	3.76	0.54	2.15	2.26	2.32	2.36

NOTE: Columns may not total exactly to 100 because of rounding.

^a Assumes Census Series E fertility.

the atypical features of Nevada's age distribution (as indexed in col. 3 of Table 3.4) will persist. (There is no basis for assuming these differences will disappear, given the likelihood of substantial future migration into Nevada.)

Operationally, the method entailed three steps. First, the relative age distribution was derived from the national Census Series E projection for each of the target projection dates (1975, . . . , 1990). The ratios in col. 3 of Table 3.4 were then used to adjust the national age distribution at each target projection date, yielding expected Nevada age distributions (cols. 4 to 7). (These all-purpose relative distributions can be used to segment any projection of Nevada's total population that is consistent with the Census Series E fertility assumption.) Applying the relative age distributions in Table 3.4 to the "low" and "best-estimate" numerical projections chosen earlier yields the age-specific projections shown in Table 3.5.

Table 3.5
AGE-SPECIFIC PROJECTIONS OF NEVADA'S POPULATION
(In thousands)

Age Group	1970 Census	Best Estimate				Low Estimate ^a	
		1975	1980	1985	1990	1980	1990
Under 5	43.9	49	59	73	74	54	67
5-9	50.7	61	54	64	74	50	68
10-14	49.6	55	53	55	63	48	58
15-19	40.2	50	53	49	60	48	46
20-24	39.1	50	60	62	51	55	52
25-29	37.5	54	37	77	78	61	71
30-34	34.1	47	65	78	59	59	80
35-39	31.4	37	49	65	77	44	70
40-44	31.1	33	38	48	63	34	58
45-49	30.8	34	35	39	48	32	44
50-54	28.0	34	36	36	40	33	35
55-59	23.7	29	33	34	34	31	31
60-64	17.9	22	20	22	30	24	27
65-69	12.8	16	19	22	24	18	22
70-74	8.3	10	12	13	15	11	14
75+	9.9	13	15	15	20	14	18
Total	488.8	584	673	759	836	616	761

^aAvailable only for 1980 and 1990. See Table 3.2.

Projections for Major Subregions of Nevada

For our purposes, we also need projections for three major subregions of Nevada: (1) the Las Vegas Standard Metropolitan Statistical Area (Clark County), (2) the Reno SMSA (Washoe County), and (3) the remainder of Nevada. The only available regional projections,⁷ though otherwise acceptable, were too far out of date for our

⁷ Unpublished projections by county, dated March 1971, prepared by S. F. Chu, Bureau of Business and Economic Research, University of Nevada, Reno. Two other sources that provide projections at the SMSA level are Curtis C. Harris, Jr., *The Urban Economics, 1965: A Multi-Regional Multi-Industry Forecasting Model*, D. C. Heath, Lexington, Mass., 1973, and Bureau of Economic Analysis, *Population and Economic Activity in the United States and Standard Metropolitan Statistical Areas, Historical and*

purposes; nevertheless, we can use their relative relationships to allocate our statewide projections among the three subregions.

Table 3.6 presents our "best-estimate" and "low" projections allocated by major subregion, based on the fractions shown in parentheses. It will be noted from these fractions that metropolitan Las Vegas is projected to gain a gradually larger proportion of Nevada's population, while metropolitan Reno's position will remain essentially unchanged. Overall, however, the projection portrays no sharp divergence among regions.

Table 3.6

POPULATION PROJECTIONS FOR MAJOR SUBREGIONS OF NEVADA
(Populations in thousands)

Major Subregion	1970 Census	1973 Estimate ^a	Projections (Mid-year)		
			1980	1985	1990
Las Vegas SMSA					
Best estimate	273.3	303.1	392.0	448.2	495.5
Low estimate	273.3	306.1	358.8	—	451.0
Fraction of state total	(0.559)	(0.556)	(0.583)	(0.591)	(0.593)
Reno SMSA					
Best estimate	121.1	134.3	165.5	186.0	204.7
Low estimate	121.1	134.3	151.5	—	186.3
Fraction of state total	(0.248)	(0.244)	(0.246)	(0.245)	(0.245)
Remainder of state					
Best estimate	94.3	110.6	115.5	124.8	135.8
Low estimate	94.3	110.6	105.7	—	123.7
Fraction of state total	(0.193)	(0.201)	(0.172)	(0.164)	(0.163)

NOTE: Fractions are derived from unpublished projections by county, prepared by S. F. Chu, Bureau of Business and Economic Research, University of Nevada, Reno, dated March 1971.

^aSource: U.S. Bureau of the Census, *Current Population Reports*, Series P-25, No. 537, December 1974.

MENTAL RETARDATION

Mental retardation is a common problem in all societies. Reacting to a variety of descriptors of mental retardation (e.g., age at onset, IQ, mental age, educability), an attempt by the American Association on Mental Deficiency (AAMD) to combine the concepts of functional proficiency and measured intelligence has gained wide acceptance:^a

Projected 1960-2020, National Technical Information Service (NTIS), July 1972. For several reasons (including lack of closure), these latter two sources could not be used with any confidence.

Chu's projection method assumes that differentials among individual county growth rates will gradually disappear, converging to the statewide rate of growth. Looked at another way, the fractions of the state total shown in Table 3.6 are assumed to stabilize at fixed values (although these stabilized values of the fractions are not expected to have been reached by 1990).

^aThe definition problem is thorny, to say the least. We refrain from trying to resolve it here, but recommend that the interested reader consult the following representative works: R. Heber, "Mental Retardation: Concept and Classification," in E. R. Trapp and Paul Himelstein (eds.), *Readings on the Exceptional Child*, Appleton-Century-Crofts, New York, 1962, pp. 60-61; and American Association on Mental Deficiency (AAMD), *A Manual on Terminology and Classification in Mental Retardation*, Monograph Supplement to the *American Journal of Mental Deficiency*, 3d ed., Washington D.C., 1973.

Mental retardation refers to substantially subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period.⁹

Under AAMD definitions, the developmental period extends up to age 18, and substantially subaverage means an IQ test score of at least two standard deviations below average (i.e., approximately 70 or below). The definition of mental retardation adopted by the American Psychiatric Association (APA) is basically the same as the AAMD definition.¹⁰

The legal definition of mental retardation in Nevada also is essentially the same as that given above: "significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period."¹¹

Mental retardation is sometimes divided into levels indicating severity: mild (Stanford-Binet test IQ of 52-68); moderate, (IQ 36-51); severe (IQ 20-35), and profound (IQ below 20).¹² Other categorizations, such as "educable" and "trainable," are often used by educators to indicate the type of special educational assistance needed; they are related to IQ only loosely, since the child's functional proficiency is a major factor in determining need for service. The AAMD relates the special education classification to IQ as follows:

Mild retardation is roughly equivalent to the educational term *educable*; moderate retardation includes those individuals who are likely to fall into the educational category of *trainable*; the severe group includes individuals sometimes known as *dependent retarded*; individuals in the profound retardation level are among those sometimes called "life-support" level. These terms are, of course, not absolute nor static. A child classified as mildly retarded may be better served in a "trainable" class than an "educable" one; some children at the severe retardation level may function successfully in a "trainable" group; children may move up or down between categories. The level does not necessarily dictate the particular service needed, but may be helpful as one criterion in planning.¹³

The term "developmental disability" includes several disabilities, of which mental retardation is the most prevalent. Specifically, a developmental disability is a substantially handicapping condition which: (1) is attributable to mental retardation, cerebral palsy, epilepsy, or to other neurological conditions found by the Secretary of the U.S. Department of Health, Education, and Welfare to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals; (2) originated before the individual reached age 18 and can be expected to continue indefinitely.¹⁴

Mental retardation is a flexible concept, a fact reflected in the experience of the so-called "disappearing retardate," i.e., a person who as a child was identified and treated as retarded but who lost that identification in later life through integration

⁹ AAMD, *A Manual on Terminology*.

¹⁰ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 2d ed., 1700 16th St., N.W., Washington, D.C., 1968.

¹¹ Nevada Revised Statutes, Chap. 433, as amended by Senate Bill 374, Sec. 20, Nevada State Legislature, 1975.

¹² AAMD, *A Manual on Terminology*.

¹³ *Ibid.*

¹⁴ *Federal Register*, Vol. 39, No. 236, December 5, 1974.

into the society. This is possible since the parameters used to identify one as mentally retarded relate both to assessments of subnormal intelligence and to adaptive behavior (which can be modified throughout the person's life-span).¹⁵

The question now is how many mentally retarded people there are in Nevada with a substantial need for one or more types of special services. The answer is that no one knows for sure, but we do know the magnitude of the number, primarily because there is a fairly commonly accepted definition of retardation (unlike the case with mental health problems) and because of the diagnosability of mental retardation (compared with mental health). Using a relatively low estimate of prevalence of 2 percent of the population yields a prevalence of approximately 11,000 retarded Nevadans in 1975 and 15,000 in 1985 (assuming our best estimate of the total Nevada population in 1985). Using the most widely quoted estimate of prevalence, 3 percent of the population, yields a prevalence of approximately 17,000 in 1975 and 23,000 in 1985. In the remainder of this section we discuss sources of data used to estimate the 2 to 3 percent prevalence range for mental retardation in Nevada. As indicated earlier, the prevalence of those needing service depends on age, and 2 to 3 percent is an average for all ages.

Considering national sources of information, the National Association for Retarded Citizens (NARC) uses a prevalence rate of about 3 percent for all ages.¹⁶ The association reports that

once a mentally retarded child reaches the age of five or six, he has a good chance of achieving normal life expectancy. In fact, the life expectancy today of mildly retarded individuals is about the same as that of nonretarded individuals. For the other levels [of severity of retardation], particularly profoundly and severely retarded persons, it is substantially less.

Of the 3 percent of the population that is retarded, the NARC provides the following breakdown: 89 percent mild, 6 percent moderate, 3.5 percent severe, and 1.5 percent profound retardation.¹⁷ Of course, those percentages are based on IQ alone; not all people with an IQ below 70 meet the second part of the mental retardation definition—deficits in adaptive behavior—and hence not all are functionally mentally retarded. In Nevada, both the Washoe Association for Retarded Citizens (Reno area) and the Opportunity Village Association for Retarded Citizens (Las Vegas area) use the 3 percent prevalence figure.¹⁸ R. Conley has conducted what is probably the most thorough recent analysis of the large number of limited studies that have been done throughout the years around the nation on the prevalence of mental retardation. Those studies show a wide range of prevalence, but his best estimate is that, nationwide, IQs less than about 70 prevail among 3 percent of the population, and that the prevalence varies by age as follows: about 4 percent for age 0 to 4 years, 3.3 percent for age 5 to 19 years, 2.7 percent for age 20 to 64 years, and 2 percent for 65 years

¹⁵ George Tarjan et al., "Natural History of Mental Retardation: Some Aspects of Epidemiology," *American Journal of Mental Deficiency*, Vol. 77, 1973, pp. 369-379, contend that as many as two-thirds of the mildly retarded adolescents and young adults lose their identification as retarded simply through aging and adaptation and/or through retesting with more sensitive instruments.

¹⁶ *Facts on Mental Retardation*, NARC, 2709 Ave. "T" East, Arlington, Texas 76011, 1973.

¹⁷ *Ibid.*

¹⁸ *A Survey of Mental Retardation in Nevada and Washoe County*, WARC, Reno, Nevada, January 15, 1973, and *Some Facts About Mental Retardation*, OVARC, Las Vegas, Nevada, July 10, 1973.

of age and over.¹⁹ Again, not all of these people are functionally mentally retarded. The U.S. Bureau of Education for the Handicapped, in its 1970 estimate of the number of handicapped children aged 5 to 19 years in the United States who need special education, used a prevalence rate of 2.3 percent.²⁰

The U.S. Bureau of the Census reported that in 1970, for the population aged 16 to 64 years, 9.5 percent were disabled in Nevada (5.1 percent in and 4.4 percent not in the labor force).²¹ These data on disability are not helpful here, since they are not disaggregated to show mental disabilities. Census data also suffer from difficulties of self-reporting, and from emphasis on the interpretation of work limitations, which are the focus of the census disability questions.

A 1973 study of the prevalence of handicapping conditions in Nevada indicated that 3 percent of the population had some mental handicap. The data are not very helpful, however, since they were based on a small and inadequate sample of clientele actually being served by Nevada agencies.²²

The most recent available data on the prevalence of mental retardation in Nevada were obtained for children under 12 years of age by a Nevada Division of Rehabilitation general population survey of 1750 Nevadans in 1974. Adults in the households surveyed were asked which, if any, of a list of conditions their children had. The list included "Down's Syndrome (Mongoloid)" and "Diagnosed Mentally Retarded."²³ This question can be expected to yield a low estimate of prevalence, since many of the undiagnosed mentally retarded children would not be reported, and some families may choose not to report the presence of a diagnosed mentally retarded child. In fact, the survey did not seek information on retarded adults because

... an extensive review of survey literature revealed no method of phrasing a question in an interview that would allow the researchers to discriminate between mentally retarded and non-mentally-retarded adults. The sensitive nature of the question in this culture precludes the direct question, 'Are you mentally retarded?' as the respondents' emotional reaction could seriously contaminate the rest of the interview. Problems with the validity of responses to this question are self-evident.²⁴

The survey data on mentally retarded children indicated 0.4 percent either had "Down's Syndrome" or were "diagnosed mentally retarded,"²⁵ a figure both we and the author of the Nevada survey report view as unrealistically low.²⁶

¹⁹ R. Conley, *The Economics of Mental Retardation*, The Johns Hopkins University Press, Baltimore, Maryland, 1973, p. 39.

²⁰ U.S. Department of Health, Education and Welfare, *Handicapped Children in the U.S. and Special Education Personnel Required—1968-1969 Est.*, Bureau of Education for the Handicapped, August 1970.

²¹ *Characteristics of the Population—Nevada 1970 Census of Population*, Vol. 1, Part 30, U.S. Bureau of the Census, January 1973.

²² K. Carpenter and L. Smith, *Incidence and Prevalence Study of Nevada's Handicapped*, Resources Development Internship Program, Western Interstate Commission for Higher Education, P.O. Drawer "P", Boulder, Colorado, Summer 1973.

²³ J. Pollard, *Survey of Nevada Rehabilitation Needs—1975*, Nevada Rehabilitation Division, Carson City, Nevada, 1975.

²⁴ *Ibid.*, p. 13.

²⁵ Interview with J. Pollard, Nevada Rehabilitation Division, Carson City, Nevada, June 10, 1975.

²⁶ *Ibid.*

Owing to the above-mentioned deficiencies and uncertainties of the Nevada survey data, especially the percentage of mentally retarded children who are not diagnosed and/or not reported in the survey as such, we cannot make a highly reliable estimate of the prevalence of retardation in Nevada. However, we feel confident in saying that 2 to 3 percent of the state population is the correct order of magnitude of the prevalence of mental retardation, and that 2 percent is probably a low estimate. These figures are consistent with what one would expect, based on national prevalence data. Retardation is known to be related to age, race, socioeconomic status, and other factors, but those relationships are not well understood quantitatively. Thus, given the basic imprecision of the total estimate, it would not be fruitful to try to adjust for various factors to make estimates of geographic differences in prevalence within Nevada.

Throughout this report, we shall estimate the need for one or more types of special services by mentally retarded people based on the conservatively low 2 percent prevalence figure. When and if programs expand and serve that 2 percent, then Nevada officials can reassess whether more than 2 percent need service in view of known unmet needs and prevalence data available at that time. Currently, not even 2 percent of the population are receiving needed services. We know from data presented in later chapters of this report that the unmet needs are large—though we are unsure exactly how large—and the appropriate policy direction is clearly toward expansion if the objective is to meet those mentally retarded people's needs.

ALCOHOL AND DRUG ABUSE

As with any target population receiving services, an assessment of the adequacy of existing programs for alcohol and drug abuse must necessarily start with a definition of alcohol and drug abuse and a determination of prevalence. At the outset, we are again beset by a host of definitional and methodological difficulties.

There are no universally accepted definitions for either alcoholism or drug addiction. There are legal definitions for intoxication while driving an automobile, usually the presence of 0.1 percent alcohol in the blood, and of course there are formal definitions for illegal possession of drugs such as heroin, barbiturates, and marijuana. But these legal definitions often refer to specific behaviors believed to endanger the public's immediate welfare or safety and not to the medical illness of addiction *per se*. Many alcohol addicts do not drive at all, and many intoxicated drivers do not have an alcohol addiction problem; a similar differentiation may be made for illegal drug use as opposed to drug addiction.

The legal definition of an alcohol or drug abuser in the Alcohol and Drug Abuse Chapter of the *Nevada Revised Statutes (NRS)* is "a person whose consumption of alcohol or other drugs, or any combination thereof, interferes with or adversely affects his ability to function socially or economically."²⁷ "Alcoholic" means "any person who habitually uses alcoholic beverages to the extent that he endangers the health, safety or welfare of himself or any other person or group of persons."²⁸ The legal definitions of an alcohol or drug abuser for purposes of commitment to the

²⁷ *Nevada Revised Statutes*, 458.010.

²⁸ *Ibid.*

Nevada Mental Health Institute are: "Alcoholic means a person so far addicted to the intemperate use of alcoholic beverages as to have lost the power of self control,"²⁹ and "Drug addict means a person who (a) habitually takes or uses any controlled substance as defined in chapter 453 of NRS, other than opium, heroin, morphine, or any derivative or synthetic drug of that group, or other than any maintenance dosage of a narcotic or habit forming drug administered pursuant to chapter 453 of NRS or (b) is so far addicted to the use of any controlled substance as defined in chapter 453 of NRS as to have lost the power of self-control."³⁰

Aside from definitional accuracy or inaccuracy, however, there are substantial methodological barriers to collecting valid and reliable data on the prevalence of particular modes of alcohol or drug use. Since excessive alcohol or drug use is considered deviant behavior by society at large, many people may be unwilling to admit to it. But even assuming honest replies, a random sample of the general population of households may miss entirely those groups with the most serious addiction problems, such as public inebriates or ghetto "street people."

In spite of the conceptual and empirical difficulties, at least an order-of-magnitude estimate of the alcohol and drug abuse problem must be made to enable the intelligent planning of treatment programs. Federal agencies and researchers in the field have used a number of methods to estimate prevalence, and these methods can be applied to Nevada. Thus far, few persons or agencies involved in Nevada's alcohol and drug problems appear to have applied these methods to any considerable extent, particularly for alcohol abuse. For example, the 1974 Nevada state plan for alcohol problems³¹ makes no application of the widely used Jellinek formulas³² for estimating alcoholism rates, other than a reference to U.S. National Institute of Alcohol Abuse and Alcoholism (NIAAA) figures for Nevada, nor does it use the relatively well-known Ledermann equations for estimating alcohol abuse rates.³³ The main empirical data submitted are based on a mail-questionnaire survey of various Washoe County groups, including a "general public" cross section with a very low 21 percent response rate. The situation for drug use is not much better; the 1974 state report relies exclusively upon arrest and death statistics.³⁴

The recent state *Rehabilitation Facility Plan* for both drug and alcohol abuse³⁵ makes some improvement by offering data from a recent state general population survey of alcohol and drug use and abuse. The 1975 *Nevada State Plan for Preven-*

²⁹ *Ibid.*, 433-348.

³⁰ *Ibid.*

³¹ Nevada State Bureau of Alcohol and Drug Abuse, *The Nevada State Plan for Prevention, Treatment, and Rehabilitation of Alcohol Abuse and Alcoholism*, Carson City, Nevada, 1974.

³² E. M. Jellinek, "The Estimate of the Number of Alcoholics in the USA for 1949 in the Light of the Sixth Revision of the International Lists of Causes of Deaths," *Quarterly Journal of Studies on Alcoholism*, Vol. 13, 1952, pp. 214-218, and Mark Keller, "The Definition of Alcoholism and the Estimation of Its Prevalence," in D. J. Pittman and C. R. Snyder (eds.), *Society, Culture, and Drinking Patterns*, John Wiley and Sons, New York, 1962.

³³ J. Hyland and S. Scott, *Alcohol Consumption Tables: An Application of the Ledermann Equation to a Wide Range of Consumption Averages*, Alcoholism Research Foundation, Toronto, Canada, 1966, and J. de Lint and Wolfgang Schmidt, "The Epidemiology of Alcoholism," in Y. Israel and J. Mardones (eds.), *Biological Basis of Alcoholism*, John Wiley and Sons, New York, 1971.

³⁴ Governor's Advisory Board on Drug Abuse, *The Nevada State Plan for Drug Abuse Prevention, Treatment, and Rehabilitation*, Nevada State Bureau of Alcohol and Drug Abuse, Carson City, Nevada, 1974.

³⁵ Division of Rehabilitation, *Rehabilitation Facility Plan, 1975-1980*, Department of Human Resources, Carson City, Nevada, 1975.

tion, *Treatment and Rehabilitation of Substance Abuse* relies primarily on that same survey for estimating alcohol and drug abuse rates.²⁶ Nonetheless, it is not clear that a general population survey with self-reporting by abusers is the best method for estimating alcohol and drug abuse, but sometimes it is the only method available.

Alcoholism

Two techniques are in widespread use at the present time for estimating rates of alcoholism or alcohol abuse. The classic method derives from an equation offered by Jellinek based on deaths due to cirrhosis of the liver, a disease known to be causally associated with heavy alcohol consumption. The second method uses statistics on per capita consumption, and assumptions about the shape of the consumption distribution curve, to estimate the percentage of a population drinking more than a specified daily amount of ethanol (absolute alcohol). Under the second method an alcoholic or, more accurately, an alcohol abuser, is defined as a person who regularly drinks more than five ounces of ethanol a day. This would be equivalent to about 12 ounces or three-quarters of a pint of 86-proof spirits, 10 cans of beer, or 1½ bottles of wine per day. In other terms, it could correspond to having two beers at lunch, two drinks before dinner, two glasses of wine with dinner, and two drinks during the evening every day.

Table 3.7 presents estimates of alcoholism rates in Nevada calculated by these two methods. There were 130 cirrhosis deaths in Nevada during 1970; this yields an estimate of 26,831 alcoholics for the state as a whole, or 7.8 percent of the population aged 15 years and over. (The convention of using 15 years and older as the population base stems from the not uncommon observation that many alcoholics start drinking heavily in their teens.)

Since cirrhosis deaths are not tabulated by county or city, the regional breakdowns in Table 3.7 are estimated by assuming rates in different areas proportional to rates shown by the recent state survey of alcohol and drug use.²⁷ The number of deaths due to cirrhosis has been relatively stable in Nevada since 1970; the figures are 130, 101, 160, 137, and 132 (projected) for 1970 through 1974. The alcoholism rate of 7.8 percent shown for Nevada in Table 3.7 therefore is probably valid for all years in this range.

The second column of Table 3.7 is an estimate of the number of persons who consume over five ounces of ethanol a day. This is an arbitrary definition of alcoholism, but it is well established that consumption at this level over many years will at least lead to higher risk for various complications such as liver cirrhosis. Overall consumption is estimated for each state in the country by retail beverage sales data. It has been known for some time that Nevada has the highest per capita consumption rate of any state in the country: 5.73 gallons of ethanol annually per person aged 15 years and over, or two ounces of ethanol per day. (The national average is 2.61 gallons. The next-highest state average is that of New Hampshire, with 4.96 gallons

²⁶ Pollard, *Survey of Nevada Rehabilitation Needs, and Nevada State Bureau of Alcohol and Drug Abuse, Nevada State Plan for Prevention, Treatment and Rehabilitation of Substance Abuse*, Carson City, Nevada, 1976.

²⁷ *Ibid.* In our opinion the overall alcoholism rate figures in the state survey are far too low, but the relative regional differences should be fairly similar over different measures.

Table 3.7

ESTIMATED RATES OF ALCOHOLISM IN NEVADA, 1970

Region	Estimate Based on Cirrhosis Deaths ^a		Estimate Based on Consumption ^b	
	Number of Alcoholics ^c	Rate ^d	Number of Alcoholics	Rate
Las Vegas SMSA ^e	17,623	9.1%	19,862	10.3%
Reno SMSA	4,722	5.5%	5,325	6.3%
Rural counties	4,486	6.9%	5,066	7.7%
Total, Nevada	26,831	7.8%	30,243	8.8%
Total, nation	3,587,458	2.7%	3,559,050	2.8%

^aUsing a modified Jellinek formula, $A = CD$, where A is total alcoholics and D is total deaths from liver cirrhosis. C is a constant reflecting the proportion of cirrhosis deaths usually resulting from alcoholism (0.828 for men and 0.216 for women) divided by the proportion of all alcoholics with cirrhosis symptoms (0.12 according to clinical studies) times the annual mortality rate (0.02 assuming an average life-span of 50 years for cirrhosis cases after onset of drinking). For Nevada in 1970, D = 130 (88 males and 42 females). Thus, C = 262 for men and 90 for women.

^bBased on the Ledermann assumptions about consumption distribution (De Lint and Schmidt, op. cit.). An alcoholic is defined as a person who consumes an average of five ounces of ethanol a day.

^cNumbers based on 1970 total adult population of 344,680, of which 56 percent is in the Las Vegas SMSA, 25 percent in the Reno SMSA, and 19 percent in rural counties.

^dRegional rate differences are based on rate differences in the state substance abuse survey (Pollard, op. cit.). Rate is percent of persons 15 years of age and older.

^eSMSA = Standard Metropolitan Statistical Area. Clark County is the Las Vegas SMSA, Washoe County the Reno SMSA.

—a value known to be inflated by the heavy purchasing of its cheaper beverages by neighboring Massachusetts residents.) Consequently, applying the Ledermann equation to Nevada's consumption rate leads to the highest per capita rate of alcoholism, with 8.8 percent of the adult population consuming over five ounces of ethanol per day, as opposed to a national rate of 2.8 percent. It is known that tourists account for a considerable portion of this consumption, of course. Nonetheless, a close correspondence exists between the estimates of Nevada's alcoholism rate based on consumption and that based on liver cirrhosis deaths (8.8 percent compared with 7.8 percent). Since cirrhosis is a long-term disease that usually does not lead to sudden death, the cirrhosis death rate is most likely a characteristic of the resident population, with few occurrences among tourists, and hence probably leads to a more accurate estimate for Nevada residents.

How do these figures compare with other data? The recent Nevada state sur-

why³⁹ yields a very low rate of 1.7 percent. A similarly low figure appears in the 1975 Nevada State Plan for Prevention, Treatment and Rehabilitation of Substance Abuse. We believe that figure to be a serious underestimate due to several causes: unconventional use of the NIAAA consumption measure (i.e., average use of 6.3 ounces of ethanol a day or above instead of the conventional 5.0 ounces or above to indicate alcoholism); surveys' missing alcohol consumers who do not reside in conventional households; and the well-known phenomenon of under-reporting of alcohol consumption in surveys of users. National studies indicate that such under-reporting may be typically on the order of 50 percent.⁴⁰ In short, unadjusted user-surveys are not accurate. One exploratory technique for correction for survey error and under-reporting, currently in the research stage, is to (1) estimate total state consumption by residents based on survey data (by multiplying the average self-reported consumption times the state population); (2) form a ratio between that estimate and a total consumption estimate based on sales (corrected for estimated consumption by out-of-staters, e.g., tourists in Nevada); and (3) use that ratio to adjust the self-reported consumption of alcohol in the survey. Employing this procedure to correct the survey data for under-reporting yields an estimate of alcohol abuse in 8.7 percent of the Nevada resident population.⁴¹ Although that estimate is based on a number of assumptions and an exploratory technique, we believe it is of the correct order of magnitude; we are also sure it is closer to the unknown true prevalence than is the unadjusted survey prevalence rate of 1.7 percent. Note the similarity of the 8.7 percent estimate obtained here and the two estimates (7.8 percent and 8.8 percent) in Table 3.7 obtained by other methods.

Data tabulated in a national study using cirrhosis deaths also show Nevada as having the highest rate of alcoholism in 1970—6.77 percent as opposed to a national average of 4.2 percent.⁴² California is second with 6.61 percent and Rhode Island third with 6.07 percent. Further, the Washoe County survey found that 7.6 percent of the general public sample classified themselves as "heavy," "hard," or "alcoholic" drinkers. While the terms "heavy" and "hard" were not defined in the Washoe County questionnaire, it might be reasonable to assume they denote consumption near the level of 5 ounces a day. This projects to a total of 6548 alcohol abusers in Washoe County, a figure close to those shown in Table 3.7.

While different methods and definitions lead to somewhat different estimates of alcohol abusers and alcoholics, the convergence of the several techniques reported here (with the explained exception of the state survey) makes two conclusions certain: Nevada has the highest rate of alcohol abuse of any state in the country, a rate that yields an alcoholic or abuser population over age 15 in 1975 of at least 33,000 (using the lowest estimate, the cirrhosis-based rate of 7.8 percent). Moreover, these

³⁹ Ibid.

⁴⁰ R. Room, *The Drinking and Drug Practices Surveyor*, No. 3, Social Research Group, University of California School of Public Health, Berkeley, California, 1971; and K. Parnanen, *Validity of Survey Data on Alcohol Use*, Addiction Research Foundation, Toronto, Canada, 1974.

⁴¹ We estimate an average consumption by Nevada residents, excluding tourist consumption, of about 1.2 ounces of ethanol per day in 1970. The estimate of average resident consumption based on user self-reporting in the survey is about 0.5 ounce of ethanol per day. Thus, $(0.5 \text{ oz}/1.2 \text{ oz}) \times (5 \text{ oz.}) = 2 \text{ oz.}$, which is the corrected dividing point we used to indicate alcoholic drinking in interpreting the Nevada survey data.

⁴² V. Efron, M. Keller, and C. Gurioli, *Statistics on Consumption of Alcohol*, Rutgers Center of Alcohol Studies, New Brunswick, N.J., 1972. This study uses a slightly different Jellinek formula from that used in Table 3.7; our formula yields a national rate of 2.7 percent.

persons are not distributed equally; nearly two-thirds reside within the Las Vegas SMSA. Projecting these figures to 1985 yields an estimated 44,000 people in the alcoholic or alcohol abuser population.

Drug Abuse

It is even more difficult to estimate drug abuse rates than it is to estimate alcoholism. Few diseases are associated specifically with drug addiction, as liver cirrhosis is with alcoholism. Even deaths caused by overdoses of certain drugs cannot necessarily be attributed to addiction; for example, they can be the result of an occasional drug user's suicidal mental depression. Moreover, since the drugs are illegally produced or purchased, there are no gross quantitative data on usage rates analogous to per capita alcohol consumption.

In this context there are only two major sources of information on drug abuse in Nevada: arrest statistics and a recent Nevada survey of substance use.⁴² Data from both of these sources are displayed in Table 3.8.

The arrest figures in Table 3.8 were taken from the 1973 Nevada State Plan for Drug Abuse. In 1972, arrests numbered 2453 for the state as a whole across all drug types, with the non-opiate drugs accounting for the great majority of cases (2108). Of the latter arrests, half were due to marijuana, perhaps the least dangerous of all illegal drugs. The Las Vegas area contributes about 69 percent of the arrests, but contains only about 56 percent of the total Nevada population. Arrest figures probably yield a serious underestimate of the true number of drug addicts, since it is assumed that the number of addicts who are never arrested exceeds the number of non-addicts who are arrested.

The second two columns in Table 3.8 present information compiled from the state survey; the same survey was the basis for data in the 1975 *Nevada State Plan for Prevention, Treatment and Rehabilitation of Substance Abuse*. While we do not believe survey methods are the best source for estimating drug abuse, and in fact we are certain the state survey underestimates alcohol abuse, there is at present no alternative method for establishing drug abuse incidence rates in Nevada. For the state as a whole, marijuana users make up almost 60 percent of the estimated 25,356 persons using drugs (weekly or more often); serious opiate addiction is estimated to afflict only 2909 persons.

Interestingly, the regional distribution is not proportional to population. The Reno SMSA has only one-fourth of the total population but nearly one-half of the drug abusers; this may be because Reno has a younger age distribution of population. It also appears that drug laws are more strictly enforced in Las Vegas than in Reno; in Las Vegas, arrest rates reflect nearly 14 percent of the survey-indicated abuser population, as compared with only 3 percent in Reno. Of course, it could also be that the survey results do not accurately reflect true abuse rates. Using the state survey results as the best available estimate, the number of opiate and other dangerous drug abusers (as distinct from drug users) numbered approximately 11,000 in 1975 and are projected to number approximately 15,000 in 1985.

⁴² Pollard, *Survey of Nevada Rehabilitation Needs*.

Table 3.8

DRUG ABUSE RATES IN NEVADA, BY REGION

Region	Total Arrests, 1972 ^a	Estimated "Heavy" Usage Based on 1974 State Survey ^b	
		Number	Rate
Las Vegas SMSA (Clark County)			
Marijuana	729	6,948	3.6%
Dangerous drugs ^c	729	4,246	2.2%
Opiates ^d	238	965	.5%
Total, Las Vegas area	1,696	12,159	
Reno SMSA (Washoe County)			
Marijuana	175	8,962	10.4%
Dangerous drugs	175	2,327	2.7%
Opiates	58	1,551	1.8%
Total, Reno area	408	12,840	
All other counties combined			
Marijuana	150	720	1.1%
Dangerous drugs	150	1,244	1.9%
Opiates	49	393	.6%
Total, other counties	349	2,357	
Nevada			
Marijuana	1,054	14,630	4.2%
Dangerous drugs	1,054	7,817	2.5%
Opiates	345	2,929	.8%
Total, Nevada	2,453	25,356	

^aTaken from *The Nevada State Plan for Drug Abuse Prevention, Treatment and Rehabilitation*, Governor's Advisory Board on Drug Abuse, Carson City, Nevada, 1973, pp. 29-30. Total arrests for each region are based on regional data; the breakdown of total arrests within each region by type of drug is based on the breakdown of the statewide total arrests by type of drug involved.

^bTaken from J. Pollard, *Survey of Nevada Rehabilitation Needs, 1975*, Nevada Rehabilitation Division, Department of Human Resources, Carson City, Nevada, 1975. "Heavy usage" in that survey means once a week or oftener. The dangerous drug rates were obtained by adding rates for hallucinogens, stimulants, and depressants. Numbers are based on the 1970 adult population of 344,680.

^cIncludes LSD, barbiturates, amphetamines, etc.

^dIncludes heroin, morphine, and other opiates.

MENTAL HEALTH

The difficulties of defining and measuring the prevalence of mental retardation and alcohol abuse pale in comparison with those associated with defining and measuring mental health. When professional mental health personnel agree upon what constitutes mental health, and reliable methods of measuring it are available, then high-quality data can be collected on the prevalence of mental health problems.

As will be seen, current definitions are vague and leave extremely wide latitude for interpretation and judgment on the part of service personnel, and virtually no

reliable data exist on the prevalence of need for mental health services in Nevada. Given this situation we cannot be definitive in specifying need for services, but must content ourselves with laying out what is known of people currently being served (in subsequent chapters of this report) and be rather arbitrary in specifying a conservative estimate of need. For purposes of this study, we consider a person to have primarily a mental health problem if he or she has a substantial need for psychological or psychiatric services due to a mental disorder other than mental retardation or alcohol or drug abuse. Of course, people with mental retardation or alcohol or drug abuse problems may also need psychological or psychiatric services, but such people are considered separately in this report.

Since mental health can be described on many different dimensions, since a person's current mental condition can fall anywhere on the continuum of each of those dimensions, and since society's views on what is "normal" change with time and circumstance, one is necessarily being arbitrary when one draws lines between "normal" and "not normal" on combinations of those dimensions. For practical reasons, society itself must arbitrarily cut through this Gordian Knot; there are people who, in the judgment of the majority of today's society, have mental health problems and need substantial psychological or psychiatric services. For purposes of planning those services, we must try to shed some light, however wavering, on the number of persons needing mental health services in Nevada.

The American Psychiatric Association (APA) has published a manual of approved diagnostic terms for "mental disorders."⁴³ It places diagnosed mental disorders into ten categories: (1) mental retardation, (2) organic brain syndromes (psychotic and nonpsychotic), (3) psychoses not attributed to physical conditions listed under organic brain syndromes, (4) neuroses, (5) personality disorders and certain other nonpsychotic mental disorders, (6) psychophysiological disorders, (7) special symptoms, (8) transient situational disturbances, (9) behavior disorders of childhood and adolescence, and (10) conditions without manifest psychiatric disorders and nonspecific conditions.

A psychosis is by definition a severe mental disorder and falls within the scope of this study. Other types of mental disorders can be classified by severity as "mild," "moderate," or "severe," and hence may include people who do not have a substantial need for special services and therefore do not fall within the scope of this study. However, the APA manual makes no attempt to define what constitutes the three levels of severity; as a result, statistics sorted among those levels are not fully meaningful.

In this Nevada study, the term "mental health problems" will include primarily the problems of people in five of the APA categories: virtually all psychotic people, and people with more severe disorders within the categories of organic brain syndrome, neurosis, personality disorder (not due to alcohol or drug abuse), and transient situational disturbances.

We first cover definitions of the APA categories, and then turn to definitions used officially in Nevada.

Definitions of mental retardation were discussed earlier. Organic brain syndromes⁴⁴ are defined in brief by APA as:

⁴³ *Diagnostic and Statistical Manual*. A new edition of the APA "Psychiatric Glossary," to be released in 1975, was not yet available at the time of this writing.

⁴⁴ *Ibid.*, p. 22. In addition to the brief definitions given, the APA Manual presents more extensive definitions of most disorders in the course of discussing subcategories of major types of disorders.

Disorders caused by or associated with impairment of brain tissue function. These disorders are manifested by the following symptoms:

- (a) Impairment of orientation
- (b) Impairment of memory
- (c) Impairment of all intellectual functions such as comprehension, calculation, knowledge, learning, etc.
- (d) Impairment of judgment
- (e) Lability and shallowness of affect

The organic brain syndrome is a basic mental condition characteristically resulting from diffuse impairment of brain tissue function from whatever cause. Most of the basic symptoms are generally present to some degree regardless of whether the syndrome is mild, moderate, or severe.

Patients with organic brain syndrome may or may not be psychotic.

Psychosis is defined in brief as follows:

Patients are described as psychotic when their mental functioning is sufficiently impaired to interfere grossly with their capacity to meet the ordinary demands of life. The impairment may result from a serious distortion in their capacity to recognize reality. Hallucinations and delusions, for example, may distort their perceptions. Alterations of mood may be so profound that the patient's capacity to respond appropriately is grossly impaired. Deficits in perception, language and memory may be so severe that the patient's capacity for mental grasp of his situation is effectively lost.⁴⁵

Psychoses may occur with or without organic brain syndrome. A frequently used diagnosis in Nevada in the latter case would be schizophrenia, which is defined in brief as:

A group of disorders manifested by characteristic disturbances of thinking, mood and behavior. Disturbances in thinking are marked by alterations of concept formation which may lead to misinterpretation of reality and sometimes to delusions and hallucinations, which frequently appear psychologically self-protective. Corollary mood changes include ambivalent, constricted and inappropriate emotional responsiveness and loss of empathy with others. Behavior may be withdrawn, regressive and bizarre.⁴⁶

Schizophrenia eludes precise definition; the manual's foreword contains the admission that "Even if it had tried, the Committee could not establish agreement about what this disorder is; it could only agree on what to call it."⁴⁷

Neuroses are briefly defined in the following terms:

Anxiety is the chief characteristic of the neuroses. It may be felt and expressed directly, or it may be controlled unconsciously and automatically by conversion, displacement and various other psychological mechanisms. Generally, these mechanisms produce symptoms experienced as subjective distress from which the patient desires relief. The neuroses, as contrasted to the psychoses, manifest neither gross distortion or misinterpretation of external reality, nor gross personality disorganization. A possible exception to this is hysterical neurosis, which some believe may occasionally be accompanied by hallucinations and other symptoms encountered in psychoses.

⁴⁵ Ibid., p. 23.

⁴⁶ Ibid., p. 33.

⁴⁷ Ibid., p. ix.

Traditionally, neurotic patients, however severely handicapped by their symptoms, are not classified as psychotic because they are aware that their mental functioning is disturbed.⁴⁸

The APA manual characterizes "personality disorders and certain other non-psychotic mental disorders" in brief as (1) disorders of personality marked by "deeply ingrained maladaptive patterns of behavior that are perceptibly different in quality from psychotic and neurotic symptoms. Generally, these are life-long patterns, often recognizable by the time of adolescence or earlier"⁴⁹ (e.g., paranoid, obsessive-compulsive, antisocial); (2) sexual deviations; (3) alcoholism, defined as occurring when "patients whose alcohol intake is great enough to damage their physical health, or their personal or social functioning, or when it has become a prerequisite to normal functioning;"⁵⁰ and (4) drug dependence, afflicting "patients who are addicted to or dependent on drugs other than alcohol, tobacco, and ordinary caffeine-containing beverages. Dependence on medically prescribed drugs is also excluded so long as the drug is medically indicated and the intake is proportionate to the medical need. The diagnosis requires evidence of habitual use or a clear sense of need for the drug."⁵¹

Psychophysiologic disorders are "characterized by physical symptoms that are caused by emotional factors and involve a single organ system, usually under autonomic nervous system innervation."⁵²

The "Special Symptoms" category includes people whose special symptoms (e.g., disturbance of speech, learning, sleep, feeding, or several other aspects of life) are not the result of an organic illness or defect or other mental disorder.⁵³

The "transient situational disturbances" category "... is reserved for more or less transient disorders of any severity (including those of psychotic proportions) that occur in individuals without any apparent underlying mental disorders and that represent an acute reaction to overwhelming environmental stress. ... If the patient has good adaptive capacity his symptoms usually recede as the stress diminishes."⁵⁴

"Behavior disorders of childhood and adolescence" is a term "... reserved for disorders occurring in childhood and adolescence that are more stable, internalized, and resistant to treatment than *Transient situational disturbances* but less so than *Psychoses, Neuroses, and Personality disorders*. ... Characteristic manifestations include such symptoms as overactivity, inattentiveness, shyness, feeling of rejection, over-aggressiveness, timidity, and delinquency."⁵⁵

We now turn to mental health definitions as used officially in Nevada. As defined in the *Nevada Revised Statutes*, "mental illness" means "any mental dysfunction leading to impaired ability to maintain oneself and function effectively in one's life situation without external support."⁵⁶ The Nevada requirement for in-

⁴⁸ Ibid., p. 39.

⁴⁹ Ibid., p. 41.

⁵⁰ Ibid., p. 45.

⁵¹ Ibid., p. 46.

⁵² Ibid.

⁵³ Ibid., p. 48.

⁵⁴ Ibid., pp. 48-49.

⁵⁵ Ibid., p. 50.

⁵⁶ *Nevada Revised Statutes*, Chap. 433, as amended by Senate Bill 374, Sec. 19, Nevada State Legislature, 1976.

voluntary court-ordered admission and emergency admission to a mental health facility is that a person "has demonstrated observable behavior the consequence of which presents a clear and present danger to himself or others, or presents observable behavior that he is so gravely disabled by mental illness that he is unable to maintain himself in his normal life situation without external support."⁸⁷ An emotionally disturbed child is defined in that same NRS chapter as someone aged 2 to 17 years

whose progressive personality development is interfered with or arrested by a variety of factors so that he shows impairment in the capacity expected of him for his age and endowment:

1. For reasonably accurate perception of the world around him;
2. For impulse control;
3. For satisfying and satisfactory relations with others;
4. For learning; or
5. For any combination of the above.⁸⁸

On the matter of the prevalence of mental health problems, a general concern for the need for better information is elaborated on by Rexford in these pointed comments about mentally ill children:

As a nation we have not been able to look honestly at the scope of the problem of emotional disturbance in children and youth nor at the size and quality of resources available to cope with these children. We have not developed the systematic surveys, the categories of conditions, the conceptual models, nor the adequate reporting and analyzing systems to know where we are.

However, concerned we may be about the lacunae in our information regarding emotionally disturbed children identified by psychiatric facilities, the total situation may be far more serious. Many of the children residing in correctional institutions, welfare homes, state schools, and foster homes undoubtedly suffer from emotional and behavioral disturbances. They may be labeled dependent, neglected, delinquent, or retarded and there is no way under present circumstances to include them in a comprehensive mental health survey. Each grouping of institutions has its own nomenclature and its own programming. There are those who believe that the reform schools and correctional institutions of the country are the sites of the same neglect of mentally disturbed young individuals as the state hospitals' back wards were of adults.⁸⁹

Comprehensive epidemiologic data in the mental health area barely exist nationally. Not only are there few consistent definitional criteria, but identification of those whose behavior is disordered or deviant is severely underdeveloped. At best, the occasional survey of patients being treated in a location gives one a crude idea about these matters, but mainly how many are being served, not how many need service. Nationally, in 1971, there were reportedly 847 patients per 100,000 population receiving inpatient psychiatric services, and 1134 per 100,000 population receiving outpatient services at state, county, private, general with psychiatric service, and Veterans Administration hospitals.⁹⁰ In addition, 305 people per 100,000 popu-

⁸⁷ Ibid., Sec. 22.

⁸⁸ Ibid., Sec. 14.

⁸⁹ Eveleen Rexford, as quoted in Joint Commission on Mental Health of Children, *Crisis in Child Health: Challenge for the 1970s*, Harper & Row, New York, 1969, pp. 257-268.

lation received inpatient, outpatient, and day treatment services at federally funded community mental health centers. The above numbers include those people who were active clients at the beginning of 1971, plus those admitted to the program during the year. There is some unknown amount of duplication of counting because of people who are admitted more than once per year and/or served by more than one program in 1971. Adding the total clients served by the different programs nationally, including the duplications, yields a total of 2286 per 100,000 population, or about 2.3 percent; eliminating duplications would probably bring the number of different people receiving some psychiatric service nationally to somewhat under 2 percent.

In an often-cited survey conducted in Manhattan in 1955, it was believed that about 10 percent of the population suffered from a "definite psychiatric disorder."⁸¹ It has become clear, however, from accumulating experience with community mental health centers across the country, that the mere opening of such a center may be enough to "surface" those in need.⁸² One wonders how many of these new clients were mentally ill all along, but were hidden away by protective and frightened friends and relatives.⁸³ It strains the credulity to think that people generally become more prone to mental illness at about the same time as the development of new programs. A further question is whether these high levels of untreated mentally ill are actually "sick," i.e., whether in fact they would be better served under other auspices than the community mental health centers. Creating community mental health centers, rather than community health centers or community social service centers, may encourage definition, labeling, and treatment of problems solely as mental health problems. Given the poor quality of available information, no one really knows the answers to these questions.

In 1970 the President's Task Force on the Mentally Handicapped concluded that 20 million Americans (about 10 percent of the population) could benefit from mental health services.⁸⁴ The national Joint Commission on Mental Health of Children cited a figure of 1.4 million youngsters under age 18 in need of immediate psychiatric care (2 percent of the young population), and further opined that this estimate by the National Institute of Mental Health was "considered by that institute and most mental health professionals to be a conservative figure."⁸⁵ The report goes on to estimate that "an additional 8 to 10 percent of our young people are afflicted with emotional problems (neuroses and the like) and are in need of specialized services."⁸⁶

⁸⁰ U.S. National Institute of Mental Health, *Utilization of Mental Health Facilities, 1971, Series B*, No. 5, Washington, D.C.

⁸¹ Leo Srole et al., *Mental Health in the Metropolis: The Midtown Manhattan Study*, McGraw-Hill, New York, 1962, Vol. 1, p. 230.

⁸² David Mechanic, *Mental Health and Social Policy*, Prentice-Hall, Englewood Cliffs, N.J., 1969, has considered this eventuality.

⁸³ Muriel Hammer, "Influence of Small Social Networks as Factors in Mental Hospital Admissions," *Human Organizations*, Vol. 22, Winter 1963-64, pp. 243-251, thinks that because of the disconnected nature of the identification and referral processes—mainly as they relate to geographic separation from primary care facilities—this may be a possible explanation for the sudden overloading of newly opened community facilities. The evidence presented is not conclusive.

⁸⁴ *Action Against Mental Disability, The Report of the President's Task Force on the Mentally Handicapped*, Government Printing Office, Washington, D.C., September 1970.

⁸⁵ *Crisis in Child Mental Health: Challenge for the 1970's, Report of the Joint Commission on Mental Health of Children*, Harper & Row, New York, 1969, p. 250.

⁸⁶ Estimated for youth aged 5 to 19 in 1969. U.S. Department of Health, Education and Welfare, *Handicapped Children in the U.S. and Special Education Personnel Required—1968-69 (Est.)*, Bureau of Education for the Handicapped, August 1970.

The U.S. Bureau of Education for the Handicapped uses a figure of 2 percent for the national prevalence of children with "emotional disturbance" severe enough to require special education services.⁶⁷

Reliable data on the prevalence of mental health problems in Nevada do not exist. The Nevada Division of Rehabilitation attempted to obtain such data through the household survey cited previously in this chapter.⁶⁸ That survey asked respondents to self-report using the question: "Which, if any, of the conditions listed below currently limit your activities?" The list included the item "emotional, nervous, or mental condition." If they said they had such a condition, they were further asked if they had "ever lost a job" or "ever been denied a raise or promotion due to this condition." Based on the survey responses, it was estimated that 1.9 percent of Nevadans over age 12 had an activity limitation due to an "emotional, nervous, or mental condition" (due to the nature of the sample, the 95-percent confidence interval for the 1.9-percent estimate is about 1.3 to 2.6 percent.⁶⁹ The comparable estimates (and confidence limits on those estimates) for three regions of the state are: Clark County, 2.3 percent (1.4 to 3.2 percent); Washoe County, 0.8 percent (0 to 1.7 percent); and all other counties combined, 1.9 percent (0.3 to 3.5 percent). In addition, 1.2 percent had lost or been denied a job and 0.3 percent had been denied a raise or promotion due to an emotional, nervous, or mental condition (no confidence limits were available on those percentages).

Regarding interpretation of the above survey data, a positive response by a person in connection with activity limitations due to a mental condition means that the person: (1) thinks he or she has some emotional, nervous, or mental condition, but we cannot know from the response whether it is minor or severe; (2) thinks he or she has some activity limitation, but we cannot know from the response whether it is minor or severe; and (3) is willing to admit perceiving the condition. For purposes of this study, the survey data on activity limitation due to an emotional, nervous or mental condition have little meaning because of the vagueness of the terms used in the survey and the inherent difficulty of obtaining valid mental health information from one or two self-reported responses in a survey. The serious problem of under-reporting mental disorders in such a survey is illustrated by the low 1.9 percent prevalence figure, which is less than the low estimates of the prevalence of mental retardation alone. Even the relationship of reported rates between various counties may not be valid, because of differential reporting rates in the three major areas of Nevada. Consequently, we must conclude that most of the data obtained on "emotional, nervous, and mental conditions" in the Division of Rehabilitation survey are grossly inadequate.⁷⁰

The question then is how one does estimate the prevalence of need for substantial psychological services in Nevada. The answer is that one cannot do so accurately. The best we can say is that the prevalence is on the order of 2 to 10 percent of the population based on national data, and that 2 percent is probably a conservatively low estimate. We can also resort to a variety of indicators. While the annual suicide rate is not an unambiguous indicator of the rate of mental health disorders

⁶⁷ Ibid., p. 254.

⁶⁸ Pollard, *Survey of Nevada Rehabilitation Needs*.

⁶⁹ Interview with Dr. Y. Koh, University of Nevada, Reno, May 12, 1975.

⁷⁰ The deficiencies of the survey on the subject of mental conditions are well known to, and acknowledged by, J. Pollard, the author of the survey report (interview, June 9, 1975).

in a population, the two rates are related. In the first half of 1974 there were 79 suicides in Nevada. That figure, according to Jack Homeyer, Vital Statistics Chief of the Nevada State Health Division, was "quite a bit above the national average."⁷¹ The expectation would have been about 33 suicides for the comparable time period if one applied the national average suicide rate for early 1974 to Nevada's population.⁷² In 1973, the latest full year for which statistics are available, the annual rate of suicides per 100,000 population was 12.0 nationally and 22.3 in Nevada.⁷³ Thus, as suggested by one measurable scale at least, the prevalence of mental disorders in Nevada may be above the national average.

Using the minimum 2 percent figure for the prevalence of mental health problems in Nevada yields an estimate of about 11,000 people in 1975 and about 15,000 in 1985. Policywise, the judicious strategy in circumstances with this much uncertainty is to expand the service system gradually, to aim to serve at least the 2 percent minimum prevalence figure, but have the flexibility to expand beyond that figure if necessary, and to reassess periodically to see if clients in substantial need of psychological and psychiatric services continue to be identified in sufficient numbers to justify further expansion.

This excursion into descriptive information on the mentally handicapped population is meant to stress the fundamental difficulty of analyzing programs and services for this group. It is difficult to obtain basic agreement as to definitions, and to obtain even "order of magnitude" information about the number and kinds of causative factors. The situation in Nevada is no exception to these general observations.

⁷¹ As reported in the *Las Vegas Review Journal*, September 28, 1974.

⁷² U.S. Department of Health, Education and Welfare, Public Health Service, *Monthly Vital Statistics Report*, Vol. 23, No. 5, Rockville, Maryland, July 26, 1974.

⁷³ Information obtained on June 26, 1975, in private communication with the Mortality Statistics Branch, Division of Vital Statistics, National Center for Health Statistics, Public Health Service, U.S. Department of Health, Education and Welfare, Rockville, Maryland.

Chapter 4

DIRECTION

Direction is an information-based service that attempts to match a client's needs with an appropriate mix of available services. It also provides coordination and continuity among the many programs designed for meeting the client's service needs. Because those needs change over time, the direction concept further requires their periodic and systematic reassessment to ensure a "best mix" of services. The notion of "best" in this context includes the amount, quality, and costs of services. The direction service we propose in this chapter would evaluate the needs of mentally handicapped people for such services as education and training; psychological services; residential treatment; residential living; vocational, medical, and financial aid; and transportation. The direction service would then coordinate their provision by other service programs. The direction service program also could coordinate such important services as prevention and identification, which are not the prime responsibility of any agency in Nevada and are provided unevenly now.

DIRECTION IN NEVADA

Direction is not well developed in most public service systems in the United States; for mentally handicapped people in Nevada, it is in a primitive state of development. No single identifiable institution in the state, in either the public or the private sector, is primarily concerned with direction. In the scattered offices that do provide some direction, it is not the main order of business and is provided typically on an ad hoc basis. Some slight and incomplete direction service is to be found in the two Special Children's Clinics in the Division of Health, in the two Mental Retardation Interdisciplinary Committees run by the Division of Mental Hygiene and Mental Retardation, and at Nellis Air Force Base for a select population of military-related people. And, doubtless, some individual public health nurses, social workers, teachers, psychologists, physicians, and others working within the system try to secure a complete range of needed services for individual clients. Despite the efforts of these unsung exemplars, the lack of coordinated services and comprehensive direction remains a major deficiency in Nevada as elsewhere.

The following are not complete characterizations of the organizations described, but rather cover those operational and structural properties that appear to be "direction-like." Subsequent chapters discuss other aspects of each organization, e.g., the prevention, identification, and education aspects of the Special Children's Clinics.

Special Children's Clinics¹

Two clinics, operated by the Nevada Division of Health and located in Reno and

¹ Information in this section was obtained in 1974 through interviews with J. Edwards, Northern Nevada Special Children's Clinic, Reno, and J. Ashbaugh, Southern Nevada Special Children's Clinic, Las Vegas.

Las Vegas, were established to provide diagnostic and some treatment services for children from birth to age 21 who demonstrate developmental delays and possible mental retardation, although the primary focus is on the birth to age 6 child. Typical treatment might include counseling of families, and preschool education and training services for a limited number of children.

Direction to appropriate services should be the next logical step after diagnosing a child as mentally retarded; but although the clinics are natural focal points for direction of the families concerned, the direction service provided is rudimentary and ad hoc. It is not defined as part of the clinics' charter and neither staff nor finances are provided for it.

Some of this direction and referral service takes place at the meetings with parents that follow the completion of diagnosis, and at a meeting of clinic staff concerning the child. Especially in the Southern Nevada Special Children's Clinic in 1974, however, there appeared to be minimal follow-up of diagnosis with service, and minimal collaboration with other agencies in 1974. As described to us in 1974 by the head of the Southern Nevada Special Children's Clinic,² "follow-up services are few and far between" and the "weakest part" of the program. In 1975, major substantive changes occurred in the entire Southern Nevada Special Children's Clinic program, which now has a new director, some new staff members, and a new facility; according to the new director, follow-up services have been substantially improved. Also, in the fall of 1975, a special education teacher from the Washoe County School District reviewed and evaluated all Washoe County children between 2 years and 6 years old who were known by the Northern Nevada Special Children's Clinic to be mentally retarded; these children were directed to programs within the school system.

Periodic reassessment and redirection are not fully implemented at the Special Children's Clinics. In both clinics, however, the clinic administrator, social worker, or a trained secretary telephone each client's family once a year to reassess the situation and, when necessary, advise on the next steps; in a few cases they arrange home or office visits with the family.

Mental Retardation Interdisciplinary Committees

Two committees are operated by the Division of Mental Hygiene and Mental Retardation, one in northern and one in southern Nevada, which review and recommend a course of services for new applicants in some division programs, and for existing clients on an ad hoc and nonperiodic basis as they may require a major change in services. The committees consist of representatives of the division, the Mental Retardation section of the Nevada Mental Health Institute, the Northern or Southern Mental Retardation Center, and specialists in psychology, social work, and vocational services. These committees do not serve all retarded people, only applicants and clients of the division's residential treatment programs at the Nevada Mental Health Institute and two Mental Retardation Centers, and the program of sheltered residential living in developmental homes. Thus, service by the committees focuses on more severely retarded people beyond about age 3, and on retarded people in their late teens and beyond. Although serving only a very limited number of people, these committees do provide multidisciplinary diagnosis and some direc-

² Interview with J. Ashbaugh, July 17, 1974.

tion to service programs both within and outside the Division of Mental Hygiene and Mental Retardation.

A pervasive problem in Nevada is the narrow range of options available. Even if the Interdisciplinary Committee wanted to provide superior direction, there is not always sufficient service capacity in programs where clients might be referred. During one Interdisciplinary Committee meeting attended by Rand researchers, a decision was reached to advise one family seeking assistance to try to avoid taking their child out of a California hospital when they moved to Nevada, and then to move on to New Mexico as soon as possible (an option the family was actively considering prior to applying for division services). The representative of the Nevada Mental Health Institute, the logical place for serving the child, said that the Institute presently had no waiting list but that it still would be a four- to six-month wait for services since the Institute was currently over capacity.

Nellis Air Force Base

Surprisingly, some of the better direction in Nevada is provided routinely through a small mental health clinic located at Nellis Air Force Base, just outside of Las Vegas. Keeping detailed records of their patient load, the Nellis facility provides as much or more direction as it does conventional service to its clients. The clientele is drawn from the base's small and limited military population and their dependents. If a patient cannot be served on the base, he or she is sent to a regional Air Force facility (an option not open to most of the nonmilitary population of Nevada) or to one of the private or public service providers in Las Vegas. The Nellis staff maintains a record of certain available local services, including a running assessment of patient treatment modalities, costs, and care received, for the purpose of directing patients who need services in excess of the small capabilities of the staff, which consists of one psychologist, one social worker, and two mental health technicians.

Among direction services provided to some degree to Air Force personnel and their dependents at Nellis are diagnosis, to determine service needs; planning, to establish an individualized course of treatment; referral, to obtain good-quality service elements integral to that treatment at lowest cost; and follow-up, to evaluate the outcomes of the prescribed treatment and to reevaluate the plan. A critical element of the direction service is missing, however: comprehensive coverage of the mentally handicapped population.

PROBLEMS WITH THE DIRECTION SERVICE IN NEVADA

The direction service—comprehensive matching of a mentally handicapped person's needs with available services—is nearly nonexistent in Nevada and is sporadic and uneven where it does occur. Follow-up, a requirement directly related to direction, is lacking. Information about the overall service system and its components, its assets, and its deficiencies, is simply not available in comprehensive form to either those needing services or those responsible for providing them. In this situation, much of the responsibility for matching a mentally handicapped person's needs with the available services falls by default to the handicapped person or to family and friends. Virtually by definition, mentally handicapped people are poorly

equipped for that task, and friends and relatives confront the same lack of information as everyone else.

Poor direction and coordination of services have stark implications for the overall operation of the service system. Without them, the system should not be expected to work very well, and it often does not. One of the major obstacles confronting us in carrying out this evaluation was the dearth of information about many of Nevada's programs. Data exist, to be sure, but they have not been compiled fully and integrated; consequently, no one can readily determine what the whole system contains, how its various parts interact, and how well it is serving Nevada's citizens. Without that information, not even top management can fully understand the problems of the service system; and at the other end, clients have little chance of learning how to "work the system" so as to match needs with service resources. A number of specific questions need to be answered.

Who are the patients and clients served by the present system, and what package of services has each received? At present, even a rough answer to those simple questions can be had only by piecing together the records of numerous agencies. Even at that, because such records as do exist are not in compatible formats, aggregates and compositional information cannot be determined readily. Furthermore, much "basic" information about the system simply does not exist.

Who are the servers in the system? Nowhere in the state is there one complete listing of all public and private service programs for mentally handicapped people, including specific information about their case loads, treatment modalities, costs, and relationships with other private and public service providers (let alone program effectiveness). Nowhere is there an up-to-date compilation of all programs in a readily understandable form so that handicapped people, their relatives, and other service providers might be fully informed about what is available throughout the state and elsewhere.

But what about consumer's choice for the mentally handicapped person? After all, he or she can "shop around" for services satisfactory both as to quality and price. Unfortunately, appeals to marketplace arguments do not suffice in this instance. The consumer may not have the resources or the time to shop around when it comes to mental health and mental retardation services.² As discussed below, information on which to make a well-reasoned consumer's choice is usually not readily available, or is not available at all. In many instances in Nevada, choice is made all the more problematic because providers and essential programs are in short supply, are often under-funded in relation to need, or do not exist at all.

But won't the client's physician (or psychologist in the local community mental health center, special educator, vocational rehabilitation specialist, social worker, or almost any other specialist) be able to tell the client or a relative where to go for help? Perhaps, but perhaps not. Besides the basic lack of information any or all of these people will have about other programs operating in the same service system, serious professional-ideological constraints are at work. An "interface" problem prevails among the physicians, social workers, psychologists, and other professionals

² Arnold I. Kitch and Leo G. Reeder, "Client Evaluation of Physician Performance," *Journal of Health and Social Behavior*, Vol. 10, No. 1, 1969, pp. 51-58, have discussed this issue in detail; Frank Riessman et al. (eds.), *Mental Health of the Poor*, The Free Press, New York, 1968, esp. pp. 88-109, are adamant and persuasive in their renunciation of the market model as a source of control for one important client group.

who jointly serve mentally handicapped people. The problem is especially difficult when questions of professional status arise, as they inevitably do. It is a problem of great consequence in Nevada, where much energy has been expended in 1974 and 1975 in what some people have simplistically billed as a conflict between psychiatrists and psychologists (primarily psychologists administering programs in the Nevada Division of Mental Hygiene and Mental Retardation).

The Nevada service programs and the people responsible for them are in flux; considerable turnover of direct service personnel exists. Therefore, the state cannot rely solely on individual staff members to provide quality direction services on a continuing basis. Certain aspects of the direction and coordination service need to be formalized if it is to be effective; as a necessary first step, for example, the information base of the service system needs to be on paper rather than merely in service people's heads, so that the information is readily transferred when personnel turnover occurs. It is better, in our view, to work hard on the creation of one or two service institutions whose primary task is to keep track of what is currently available, both locally and in contiguous states, so as to lessen the search and discovery time for those in need of services.

The uncertainty about the current and future size of the mentally handicapped population (see Chap. 3) adds another dimension to the direction service requirement. It is essential that overall system planning be tied to effective record-making and record-keeping so as to alert top-level decisionmakers as soon as possible to fundamental changes in the aggregated population's service needs. Lacking comprehensive, aggregate information on the nature of the population's service needs, which a direction program could help provide for all those in receipt of services, planning tends to become a reactive rather than an anticipatory activity.

Defective or nonexistent coordination and communication among programs and service providers pervades the service system in Nevada and does not seem to be readily or easily correctable. Inadequacies of current coordination and communication among programs were mentioned in most of the interviews we conducted. The following examples are only illustrative. When we asked the Nevada Governor's Mental Hygiene and Mental Retardation Advisory Board what they felt were problems with current services, the first three mentioned were: (1) how to deliver and finance services in rural areas; (2) communication and lack of continuity of therapeutic service upon patient release from the Nevada Mental Health Institute (an example was cited in which the family and private psychiatrist of a patient released from the Institute first learned of his release when he arrived home in Las Vegas); and (3) the public does not know whom to get service from or what service is available.⁴ In our terminology, the second and third problems cited concern the lack of direction service in the state. Another example of lack of coordination stems partially from the problem of insufficient funding for a service program in relation to need: speaking of the Henderson Mental Health Center, a high-level staff member at that Center said, "We don't want to advertise because we're already swamped, but I guess we should let more people know about our work to improve coordination."⁵ The lack of cooperation is not restricted to the public sector; one private provider indicated that "the competitiveness for dollars among private agencies goes

⁴ Interview with Governor's Mental Hygiene and Mental Retardation Advisory Board, Las Vegas, Nevada, January 6, 1975.

⁵ Interview with Mr. Eversaul, Henderson Mental Health Center, Henderson, Nevada, July 16, 1974.

over into service provision."⁸ An improved direction and coordination service is no instant cure for these difficulties, but it should help considerably.

Deficient follow-up is a basic and unresolved problem for mentally handicapped people and their families. There is little comprehensive and continuing follow-up to insure that they are integrated into their communities or into other service programs when they have completed a course of treatment or have ceased receiving specialized services in a particular program, e.g., residential treatment, special education, or vocational training.

A direction and coordination service can be created to help resolve many of these problems, and the means for doing so are well within the resources and abilities of Nevada.

REGIONAL DIRECTION CENTERS

Basic Requirements for a Direction Service

Adequate coordination and direction have not been achieved and probably cannot be achieved by relying solely on the individual staff members of various programs. We believe it is better to establish a separate state program responsible for direction and coordination of the service system on behalf of individual clients. The information essential for direction and coordination comes from all service programs, and it is more efficient to have that information available and up to date in one place than to try to keep every program up to date on every other program in sufficient detail so that every program could provide a complete and effective direction service. Assigning direction and coordination responsibilities to a separate program staff also would visibly place primary responsibility for direction with that staff, and would eliminate the possibility of having direction and coordination be neglected because attention is diverted to meeting other pressing service demands (as can easily happen when a program is primarily responsible for some other service). Another argument in favor of having a separate state direction program is that there are interdependencies among different service programs that may not be adequately taken into account if direction were to be provided by each of those various programs rather than by a separate state-level program. For example, benefits and costs of a service program may be received or borne beyond the bounds of that particular service program; these benefits and costs can be termed "externalities" from the viewpoint of that particular service program. If direction and coordination of client services by each of these particular service programs is provided by a separate state program, then certain factors that are external from the particular service program's viewpoint can be internal from the viewpoint of the state direction program with its broader perspective. Furthermore, it is unlikely that anything less than a separate state direction program will achieve the desired coordination of services for individuals, since it is unlikely that other existing state service programs can be effectively coordinated in practice by personnel who are not placed above those programs in the bureaucracy.

We consider the following to be critical requirements for a quality direction and

⁸ Interview with R. Junius, Easter Seal Society, Las Vegas, Nevada, January 6, 1976.

coordination service program, to be administered by the Regional Direction Centers we recommend below. The program should:

- Be a well-publicized *point of entry* to the service system and a one-stop source of both general and specific information for Nevada citizens in need of services because of mental handicaps.
- Collect and maintain information about all components of the public and private system serving mentally handicapped people in Nevada so that individuals can be effectively matched with the appropriate available services.
- Emphasize the individual, human dimension to create a specific and comprehensive service plan for each client's particular needs to the extent feasible with the existing service system, and coordinate with other programs to obtain needed available services for the client.
- Serve as a representative for individual clients in interacting with the service system to facilitate service delivery.
- Provide for periodic review, through active follow-up, of the appropriateness of the mix of services being provided to each client in light of changing needs and programs.
- With adequate privacy safeguards, collect and maintain information on each client served by the system, for the client's and the system's *mutual* benefit, in order to facilitate follow-up, coordination of other service programs in meeting the client's needs, and in the aggregate to provide information on needed improvements in the service system.
- Provide a multidisciplinary staff, since people trained in single disciplines generally cannot provide all needed expertise on the continuum of service needs of mentally handicapped people.
- Provide separate staff expertise for people with needs due to (1) mental health problems, (2) mental retardation, and (3) alcohol and drug abuse problems, since the service needs and programs for serving those groups are significantly different.
- Provide direction and coordination as the primary service of the program, so that attention is not diverted to the meeting of other pressing service demands.
- Be separate from other major direct service programs in the bureaucracy, so that it is not captured by those programs, and so that too much emphasis is not placed on direction to certain services.
- Provide the direction service program as part of the public rather than the private service sector, since it is unlikely that the public sector programs could be coordinated by the private sector.

Regional Direction Center Recommendation

We recommend that Regional Direction Centers be established: in Reno serving all of northern Nevada, and in Las Vegas serving all of southern Nevada, with separate but cooperating staffs for mental health, mental retardation, and alcohol and drug abuse clients. We further recommend that these centers be placed under the operational control of the Nevada Department of Human Resources, and be placed above the administrative level of the various divisions providing the services that the Regional Direction Centers would coordinate. Since not all service programs are within the Department of Human Resources, e.g., education and private service programs, the Direction Centers may need legal authority to coordinate with

and exchange information with other public programs, and to provide limited information (with the individual's permission) to private service programs. Privacy safeguards on the information will be essential.

These Direction Centers could operate under the auspices of the Nevada Governor's Mental Hygiene and Mental Retardation Advisory Council, the Nevada Developmental Disabilities Council, and the Nevada Alcohol and Drug Abuse Advisory Board, all of which we have recommended be strengthened significantly (see Chap. 2).

These Regional Direction Centers should be configured to meet the basic requirements for a quality direction service noted above. Direction Center personnel would provide diagnostic, planning, referral, and follow-up services either directly or through consultants who would supplement regular direction service providers. However, it would not duplicate other services, such as diagnosis, if provided adequately in other programs (e.g., a mental health center or rehabilitation program). Initially, the Direction Center personnel would not have direct authority over other operating program personnel but would attempt to coordinate services to individuals through persuasion and the exchange of information. Later, if the voluntary approach to coordinating services for individuals proves inadequate in Nevada, the Direction Centers might need to be given greater powers. The intent, under this concept, is not to duplicate existing services or to dictate to existing programs, but to make them more coordinated, responsive, and effective.

Diagnosis would be a primary function of the Direction Center, particularly for mentally retarded and alcohol or drug abusing people. Mental problems are complex and normally demand resolution from many different perspectives. Diagnosis could include the services of a direction counselor as well as personnel skilled in diagnosing specific types of mental handicaps. Consultative assistance, of the type found in practice in Reno's Special Children's Clinic, for example, would draw on the talents of medical specialists, mental retardation professionals, and other specialized talent. Besides collection and collation of previous diagnoses and work-ups on clients entering or reentering the Nevada service system, a basic purpose of the initial diagnostic intake would be to reevaluate, only if necessary, the current nature and extent of the individual's handicapping condition. Where necessary, additional diagnostic testing and evaluations may be required before a plan of service for a specific client can be formulated. Direction Center personnel, e.g., the direction counselor assigned to the specific case, would be responsible to see that these additional tests and evaluations are carried out if (and only if) needed, ensuring that duplication of diagnostic and other studies is minimized or eliminated. Evaluations will necessarily vary from case to case, but in all cases the paramount objective will be to determine as well as possible the client's level of functioning and needs.

At the conclusion of the intake and diagnostic portion of direction, a planning phase would follow. Once again, such planning is necessarily multidisciplinary. Its intent would be to assess the client and his or her situation, to clearly establish the needs, to set goals in both near and longer terms, and to develop an individualized plan of service and action consistent with available services. The products of this phase would be information that would be made available to individual servers to the extent necessary, and a step-by-step course of action that the client and his or her family could pursue.

The process would not stop with diagnosis, planning, and referral for service;

follow-up is an important step to help ensure that what has been planned is carried out as intended.

A toll-free telephone number should link the centers and provide access for citizens and service agencies throughout the state. As soon as the centers become fully operational, this number should be widely publicized. It would help if an easily remembered number were selected, e.g., something like 800-SERVICE or 800-COUNSEL.

While the start-up costs of the Direction Centers might be derived from private sources, the centers should be publicly operated. This is primarily a service for the general consuming public. If it were privately operated, it would in our view be much harder to attain public agency cooperation and to obtain public program case information, both essential to success. If it were not organizationally situated to ensure direct access to the Director and the bureaucratic power of the Director of a Department, we fear that much of the desired effectiveness would be forfeited. At the Department of Human Resources level, potential coordination benefits appear significant.

Although, to enhance their effectiveness, the Direction Centers should report to a very high level in the bureaucracy, we believe they must operate at the local level and interact with the direct service providers at the local level to achieve the best coordination of services for the client's benefit.⁷

One could argue that an elegant and expensive computer system would be necessary for an institution whose basic purpose includes the collection and dissemination of information. Such systems exist,⁸ but we believe Nevada does not need one, because of the relatively small size of its at-risk population. Conventional record-keeping methods should suffice; if they prove burdensome in the future, the operation can be computerized.

We recommend starting small, with a staff of perhaps 6 at the Northern and perhaps 12 at the Southern Nevada Regional Direction Centers. The operating procedures could be developed, tested, and refined on this small scale with limited numbers of clientele. If shown to be worth the relatively small cost per client, they could then be expanded later to meet the full direction service needs of various types of mentally handicapped people.

A possible method of paying for these direction centers—one requiring legislative consideration, in all probability—would be to earmark a very small, but fixed percentage of all service funds currently provided, e.g., 1 percent, for use in providing direction and coordination services. For instance, a mentally retarded child is entitled to special education, and special education is costed separately in the state's current operating budget. If only a small fixed "tax" were levied on the special education budget, and in similar fashion on all other programs providing services, a pool of continuing funds could be created to operate and sustain the programs of the Regional Direction Centers.

Volunteers might be used to reduce costs, as they are in some prototype direc-

⁷ For discussion of a series of efforts to coordinate mental health systems, see Martin Gittelman, "Coordinating Mental Health Systems: A National and International Perspective," *American Journal of Public Health*, Vol. 64, No. 5, May 1974, pp. 496-500, where this concluding comment, of applicability to Nevada as well, is made (p. 500): "Get it all together through action and coordination and responsibility at the local level. No edicts or management from above can do the job; responsibility for, and direction of, services must be centered in the community."

⁸ The State of Maryland's "Data System for the Handicapped" is a notable and operational example.

tion programs of which we are aware. One offsetting cost reduction would come from elimination of the need for other programs to provide their present inefficient and partial direction, which is based on little comprehensive information about the service system. In view of the potential for standardized, accurate, and rapidly accessible management information (currently available in only the most rudimentary forms), this direction service expenditure could provide significant benefits. It is difficult to assign a dollar value to the additional humane, quality-of-life benefits that would accrue to mentally handicapped people and their families from receipt of appropriate services, but the value must be significant. Similarly, it is not possible to calculate exactly the benefits deriving from savings in services that people will not need later in life because of timely evaluation of needs and case management, but the savings would be significant in the individual case and positive in the aggregate. The savings in rediagnosis and recertification realized by a simple transfer of client records from the Direction Center to various other servers will be considerable, but not reliably calculable. The savings that would result from more efficient matching of the needs of a handicapped person with the locally available services are not measurable, using available data, but would be positive.

In brief, the cost per person for a direction and coordination service is not in itself high, and the potential benefits and later savings from that service could be large, but they cannot be accurately estimated using available data.

Some Other Examples

It should be stressed at the outset that this Regional Direction Center recommendation differs in significant ways from specific proposals advanced in earlier Rand analyses⁹ and from current operations of the California Regional Centers for the Mentally Retarded.¹⁰ While many of the operational concerns have been derived from our analyses of direction needs of handicapped children, as reported in our work for the Secretary of the Department of Health, Education, and Welfare, one must consider some important adjustments in adapting the concepts to Nevada.

Our prior work was concerned only with sensorially handicapped children, whose direction needs generally converge with the needs of the mentally impaired of all ages in Nevada, but for whom specific differences exist with respect to methods of identification, diagnosis, and follow-up. For instance, less direct contact is thought to be necessary for sensorially handicapped children, whose difficulties tend to stabilize once all available medical remediation has been administered. By contrast, a mentally ill adult conceivably may never achieve a long-term and steady state condition, depending on the nature of the disorder; that fact implies a quite different pattern of intake, diagnosis, planning, and periodic review. At the least, provision for more frequent and ready access to the direction service would have to be designed for mentally handicapped people, and the disciplines represented in staffing will depend on the type of handicap.

In scale of operations, the sensorially handicapped population's direction needs differ vastly in scale from those the mentally impaired in Nevada would require.

⁹ See J. Kakalik et al., *Improving Services to Handicapped Children*, The Rand Corporation, R-1420-HEW, Santa Monica, California, May 1974, Chap. 3.

¹⁰ For a description and evaluation of the California experience, see Robert N. Larson et al., *Community Services for the Developmentally Disabled*, Program Review Branch, Aclits Div., Dept. of Finance, State of California, Report PR-78, Sacramento, August 1978, esp. Chap. 4.

Catchment areas for direction of sensorially handicapped children are several times as large in design because of the much lower incidence rate of sensorial handicaps; many more and different service providers have to be accounted for than would be required in Nevada; and the use of the computer is a necessity.

A basic difference between what we propose here and the California Mental Retardation Regional Centers is that the California Centers can purchase services on their clients' behalf from other public and private programs; arguments can be marshalled to support this economic "stick," to insure that services are provided at reasonable cost and quality. For Nevada, with its much smaller and more easily manageable service system, the potential benefits do not appear to justify disruption of the current system by having most funding flow through the Regional Direction Centers. The California Centers themselves also provide some services that are not basically informational or directional, a practice that diverts the institution somewhat from its basic purpose. For example, they often provide long-term social worker services; they are responsible for all admissions and discharges from state hospitals; and they are deeply involved with so-called "Area Boards" in the development of detailed regional plans. The California Centers also typically serve mentally retarded children and a provision of the enabling legislation allows them to maintain a client for life in the event the condition causing the handicapping is permanent. Other differences exist, but these are the major ones.

One final key aspect is that the California Centers have been vested with the legal right to guardianship for their clients, i.e., the legal right to act as a "wise parent" if a client's parents or guardians decide to relinquish this responsibility to the Director of the State Department of Health through court action. Such a guardianship role might also be considered for the Nevada Regional Direction Centers, whose creation we propose.

For more details on the direction center concept, and a review of several other types of direction-like programs throughout the United States and in Europe, refer to our earlier report on services to handicapped children.¹¹

¹¹ Kakalik et al., Chap 3.

Chapter 5

PREVENTION

INTRODUCTION

Traditionally, two classes of prevention have been distinguished: primary and secondary. Primary prevention tries to forestall some harmful process or event. Secondary prevention concentrates on early identification and treatment, so that the consequences of the potentially debilitating process or event either do not appear or are rendered less harmful. Standard public health doctrine also considers the possibility of tertiary prevention, efforts to reduce the duration of negative effects through a course of treatment.

Eli M. Bower has further refined and qualified these general prevention definitions for use by mental health practitioners:

- Primary refers to those activities done for the entire "population at large," not specifically the handicapped population.
- Secondary is done for the limited population of "identified vulnerable, high-risk groups."
- Tertiary includes all "treatment and rehabilitation" of handicapped people.¹

Prevention of mental disorder is so self-evidently a "good" objective that no one can dispute its usefulness or desirability, but only its costs, methods, and feasibility. Politicians have occasionally turned prevention into a rallying cry, as President Kennedy did in 1963:

First, we must seek out the causes of mental illness and of mental retardation and eradicate them. . . . For prevention is far more desirable for all concerned. It is far more economical and it is far more likely to be successful. Prevention will require both selected specific programs directed especially at known causes, and the general strengthening of the fundamental community, social welfare, and educational programs which can do much to eliminate or correct the harsh environmental conditions which often are associated with mental retardation and mental illness.²

Prevention is far harder to practice than to preach, however. Experience has shown that prevention not only is difficult to define, it is even more troublesome to put into action. Nevada is a case in point. The state's programs for the prevention of mental disorders are in an embryonic, underdeveloped stage, but Nevada is not at all alone in that regard.

Several explanations are possible for the stunted growth of prevention pro-

¹ Eli M. Bower, "Primary Prevention of Mental and Emotional Disorders: A Frame of Reference," in N. M. Lambert (ed.), *The Protection and Promotion of Mental Health in Schools*, U.S. Public Health Service Publication No. 1236, Washington, D.C., 1966.

² John F. Kennedy, "Message from the President of the United States Relative to Mental Illness and Mental Retardation," *House Document No. 58*, 88th Cong., 1st sess., Government Printing Office, Washington, D.C., 1963.

grams in Nevada and elsewhere. One may be that officialdom undervalues the investment in preventive activities. Conserving today's prevention funds may make good short-term economic sense to a hard-pressed public official; in the long run, such a policy may be penny-wise and pound-foolish. What appear to be savings—even small savings—may inflict prolonged and expensive consequences when one considers the high human and economic costs of an impaired individual over the years, to both the person and to society.³ Underinvestment in this neglected service may also occur because those who administer, or who are supposed to create and administer, preventive programs do not reap for their own agencies the savings that prevention realizes in such services as special education, vocational services, and welfare, which are administered elsewhere. Another reason for neglect is that basic knowledge about the causes and cures of many mental disorders is inconclusive or missing. That is not true for all mental disorders, however; many causal connections and preventive measures are known and those measures should be undertaken to a far greater extent.⁴ Also, no one agency of government has been assigned responsibility for prevention in a direct and inclusive way, at either the federal, state, or local level.

The following three sections of this chapter deal with the prevention of mental health disorders, mental retardation, and alcohol and drug abuse. Each summarizes the state of knowledge about and practice of prevention throughout the country, describes the status of prevention activities in Nevada, and makes recommendations for improvements when warranted. The discussions are limited wherever possible to primary and secondary prevention. Subsequent chapters of this report that describe treatment services deal more fully with tertiary prevention through treatment of people with mental handicaps (e.g., special education so that a mentally retarded child is not functionally retarded as an adult).

Current expenditures in Nevada for the prevention of mental handicaps are impossible to estimate accurately; so is the number of handicaps prevented. Some very small but inestimable fraction of programs to improve societal-environmental living conditions for the general population can be considered as going for primary prevention of mental handicaps. More directly, some small fraction of expenditures for maternal and infant care, counseling, family planning, nutrition, immunizations, Medicaid, and other programs contribute partly to the prevention of mental handicaps, but we have no meaningful way of estimating that fraction with available data. The following are the only expenditures we located that we could specifically attribute to the primary and secondary prevention of mental handicaps: alcohol and drug abuse education, currently about \$300,000 a year; genetic testing and counseling for mental retardation, about \$75,000; and less than \$50,000 for Crisis Call and Suicide Prevention telephone programs.

PREVENTION OF MENTAL HEALTH DISORDERS⁵

So little is known about the specific causes and prevention of mental health

³ This is precisely the conclusion of Ronald W. Conley, *The Economics of Mental Retardation*, The Johns Hopkins University Press, Baltimore, Maryland, 1973, a sophisticated and convincing analysis of service programs for the retarded.

⁴ Malin Van Antwerp, "The Route to Primary Prevention," *Community Mental Health Journal*, Vol. 7, No. 3, 1971, pp. 183-188, notes the dearth of research undertaken nationally to determine these factors.

⁵ As primary sources we use information obtained from our medical consultants; for textual documentation we use Frederick C. Redlich and Daniel X. Freedman, *The Theory and Practice of Psychiatry*, Basic Books, New York, 1968, esp. Chap. 10.

disorders that preventive measures lack precision and it is difficult to evaluate their effects. Prevention of mental illness is not a new idea; but it is seldom made into an operational program. Even successful prevention is hard to prove. The central predicament is dramatized in the following commentary on the causes of manic-depressive behavior disorders, thought to account for as many as three to four mentally ill persons per 100,000 population (so afflicted as to require in-patient care):

Although etiological theories are many, our knowledge of the causative factors is scanty, and we must view affective behavior disorders as of unknown and exceedingly complex etiology. Statements about etiology in the literature do not differentiate between severe and mild disorders, between single depressive or manic attacks and recurrent and cyclic disorders. In general, it is assumed that in severe and cyclic disorders, organic factors, and in milder and sporadic reactions, psychological events are more likely to be contributory. This clearly is a gross oversimplification.⁶

Other disorders of mental health are similarly opaque to reliable and consistent etiologic discrimination.

Table 5.1 provides some crude suggestions about conditions that account for mental disorders, and compares age cohorts according to primary diagnoses. The large percentage of the total devoted to "Other"—25 percent—again reflects the crudity of etiologic knowledge.

Because available data are so poor, it is a matter for debate whether biology or environment is the greater force in mental health disorders (although there are those who believe otherwise⁷). It appears that "Major disorders are, indeed, distributed more or less equally through space and time," and that "all major disorders seem to occur in all cultures,"⁸ but then again, no one really has adequate evidence about the prevalence and causes of mental health disorders.

How does one "prevent," in the crudest sense, disorders whose causes are so poorly understood?

Genetic control programs are of no significance in practice today. In the absence of etiologic data, genetic counseling for mental health problems has yet to pass from the realm of academic inquiry into application. If and when it does, the questions we raise later concerning genetic counseling in the mental retardation area will have to be addressed. Researchers have explored schizophrenic families and occasionally deduced that the children of such families tend to be socially and psychologically maladjusted.⁹ But are they so because of their genes or because they are reared in an unstable environment? (In either case, some people argue that psychot-

⁶ Ibid., p. 539.

⁷ In a much-heralded work, M. Harvey Brenner divined a consistent relationship between economic cycles and mental hospital admissions.

First, it is clear that instabilities in the national economy have been the single most important source of fluctuation in mental-hospital admissions or admissions rates. Second, this relation is so consistent for certain segments of the society that virtually no major factor other than economic instability appears to influence variation in their mental hospital rates. Third, the relation has been basically stable for at least 127 years and there is considerable evidence that it has had greater impact in the last two decades.

Mental Illness and the Economy, Harvard University Press, Cambridge, Massachusetts, 1973, p. ix.

⁸ Radlich and Freedman, *The Theory and Practice of Psychiatry*, p. 5.

⁹ See for example, Ronald O. Rieder, "The Offspring of Schizophrenic Parents: A Review," *Journal of Nervous and Mental Disease*, Vol. 157, No. 3, 1973, pp. 179-190. Most of the ongoing work in this area as of 1973 is noted in his review.

Table 5.1

**ESTIMATED NUMBER OF TOTAL TERMINATIONS FROM OUTPATIENT PSYCHIATRIC
CLINICS IN THE UNITED STATES BY MENTAL DISORDER AND AGE, 1969**

Diagnosis	All Ages	<5	5-9	10-14	15-17	18-19	20-24	25-34	35-44	45-54	55-64	65-74	75+
Total	818,865	15,426	80,049	113,751	79,959	37,220	96,307	153,142	115,843	70,567	34,786	14,635	8,180
Mental retardation	29,879	2,900	8,180	7,931	3,183	1,186	1,755	2,042	1,211	836	451	113	91
Organic brain syndromes associated with alcoholism	4,833	—	—	13	35	45	227	726	1,155	1,352	890	278	81
Organic brain syndromes associated with syphilis	552	—	13	82	30	7	13	53	57	84	138	52	33
Organic brain syndromes associated with drug or poison intoxication	2,770	2	20	94	371	357	765	486	283	182	123	52	35
Organic brain syndromes associated with cerebral arteriosclerosis and small brain disease	5,388	—	3	5	4	2	5	35	61	229	1,002	2,165	1,577
Other organic brain syndromes	16,746	904	3,598	2,552	981	474	1,141	1,664	1,488	1,386	1,234	762	562
Schizophrenia	100,784	480	1,717	2,897	3,860	4,331	14,333	27,158	23,381	14,189	6,000	1,777	641
Major affective disorders	12,519	7	13	25	69	70	443	1,045	2,043	3,834	3,465	1,218	386
Psychotic depressive reaction	5,470	6	23	85	141	128	477	1,021	1,185	1,001	847	390	166
Other psychoses	3,371	17	47	85	90	112	352	575	636	657	520	217	63
Depressive neuroses	70,340	89	507	1,967	2,594	2,854	10,626	19,504	14,682	9,467	5,410	1,983	667
Other neuroses	56,060	218	2,679	4,581	2,685	2,522	9,108	15,865	10,056	4,892	2,237	694	483
Personality disorders	124,455	430	4,914	13,769	12,996	7,281	22,192	31,441	18,980	8,908	2,477	840	537
Alcohol addiction	17,188	3	2	22	64	91	565	3,373	5,696	4,861	2,074	347	89
Drug dependence	7,558	—	2	122	648	867	2,127	2,134	1,013	401	152	65	27
Psychophysiological disorders	5,119	35	317	502	372	207	616	1,126	1,018	614	345	128	39
Transient situational disturbances and adjustment reaction to infancy	14,069	2,115	27,610	41,326	29,822	7,924	9,262	11,154	7,337	3,545	1,453	833	708
Other	211,544	7,230	30,404	37,693	22,014	8,722	21,299	33,740	25,530	14,429	5,937	2,721	1,795

SOURCE: Unpublished data from the National Institute of Mental Health, HSMHA, as reported in the *Mental Retardation Sourcebook of the Department of Health, Education, and Welfare*, DHEW publication No. (OS) 73-81, September 1972, p. 91.

ic parents should not attempt to rear children at all.¹⁰) In a massive compilation of family data spanning four generations, Sheldon Reed and his associates have done a great service in terms of basic data collection, but nonetheless, they are able only to "suggest" the possibility of hereditary factors in psychosis.¹¹

A large literature on neurotic etiologies has amassed over the years, but hard knowledge remains in short supply. David Cohen has recently summarized work in this field; however, his concluding comment about needed further research speaks for itself.¹²

This kind of research would be worth the enormous time, expense, and effort required. It would facilitate the development of true theories capable of predicting onset, duration, intensity, and type of reaction.

Providing a stable and stimulating living environment is a preventive "good,"¹³ but then, so are many similar activities. Teaching people how to know themselves, to perceive and understand reality, to make realistic plans, to relate to others, to care and be cared for, to accept and deal with change, to accept responsibilities, and to practice effective birth control are all potential preventive approaches. Each has proponents and detractors, and each has some claim to legitimacy. For all of these approaches there exist related intervention practices, but for all of them—approaches and practices alike—the preventive aspect of reducing mental health disorder is still open to question. There is less doubt about the need to increase public awareness of mental health problems (most books on the issue recite that need like a litany), but even here there are few clear prescriptions,¹⁴ many all-too-clear problems,¹⁵ and not many notable successes.

It is hard to disagree with those who urge more research and more attempts at primary prevention.¹⁶ Knowledge is what we need; we are still far from being able to make confident recommendations about preventive "activities done for the 'population at large,'" to recall Bower's operational classification scheme discussed at the beginning of this chapter.

Society is somewhat better equipped to provide secondary prevention to help "identified vulnerable, high-risk groups," but there are problems here, too. A person with a high risk of developing a mental disorder is too seldom in touch with skilled mental health providers to be identified early, so that secondary preventive measures can be taken. More often than not the disorder develops and advances over an

¹⁰ Michael Rutter, *Children of Sick Parents*, Oxford University Press, New York, 1966, examines many aspects of this question.

¹¹ Sheldon C. Reed et al., *The Psychoses: Family Studies*, W. B. Saunders, Philadelphia, Pennsylvania, 1973.

¹² David B. Cohen, "On the Etiology of Neurosis," *Journal of Abnormal Psychology*, Vol. 83, No. 5, 1974, pp. 473-479, at p. 478.

¹³ Gerald Caplan (ed.), *Emotional Problems of Early Childhood*, Basic Books, New York, 1965, is a standard although dated source.

¹⁴ S. Richard Sauber, *Preventive Educational Intervention for Mental Health*, Ballinger, Cambridge, Massachusetts, 1973, has detailed a thorough, logical plan for public education and this work warrants attention. The results are not in yet, however. Gerald Caplan, a prominent spokesman for prevention, has laid out some of the requisites in his *Support Systems and Community Mental Health*, Behavioral Publications, New York, 1974.

¹⁵ Elaine Cumming and John H. Cumming, *Closed Ranks*, The Commonwealth Fund, Cambridge, Massachusetts, 1967.

¹⁶ The optimistic note resounds in Gerald Caplan, *Principles of Preventive Psychiatry*, Basic Books, New York, 1964. The pessimistic echo is that the Federal Government in 1974 was spending only about \$3 million a year on the problem. The near-term prognosis is not roseate.

extended period of time as the person becomes a subject of concern and perhaps hostility to family, friends, co-workers, physicians, ministers, teachers, and so on. Ultimately, if fortunate, the person is taken on by a competent psychologist or psychiatrist, by which time the object is treatment, not prevention. Procedures should be designed to make the mental health service system and its prospective clients more readily accessible to each other.¹⁷

One especially interesting example of a program that makes the mental health service system more accessible is the Suicide Prevention and Crisis Call Center in Reno. Its experience also illustrates many of the typical problems found in this and other sectors of the system. The Reno Center is a joint operation between the University of Nevada and volunteers,¹⁸ partially financed in the amount of about \$7000 per year by United Way. The University provides the building rent-free and offers a semester of training for the volunteers who answer the telephones. There are 75 nonprofessional volunteers and 11 professional back-ups, e.g., social workers, psychologists, ministers. The Center operates 24 hours a day, but offers telephone assistance only—no walk-ins. A total of 4589 initial calls were received in 1973; only about 10 percent were not related to crisis or suicide. As to be expected, the calls are rather long and result in referrals to other community agencies. The Center tries to call back later to check on the troubled persons, but does not always succeed. Professionals do not usually answer the phones, but provide backup. About 10 to 20 percent of the calls are in fact suicide-related; the remainder are concerned with depression, psychosis, lodging, food, and so forth. As of April 1974 it was the only 24-hour service of its type in northern Nevada (the Reno Mental Health Center, however, has recently begun answering its telephone on a 24-hour basis). Despite these impressive beginnings, there are problems. Outside of the hours from 8 a.m. to 5 p.m. on weekdays, direct services from psychologists and psychiatrists were said to be often unavailable; and not many people know about the center and its program. (In a recent survey, less than 5 percent of those questioned had even heard of the Reno program.¹⁹) Las Vegas has two similar privately financed 24-hour telephone programs called the Hotline and the Suicide Prevention Center.²⁰

While the Community Mental Health Center (CMHC) movement, often hailed as a "third revolution" in mental health,²¹ was intended to tackle both prevention and treatment, it is clear from the record that prevention has remained more promise than actuality.²²

¹⁷ Redlich and Freedman note one actual case, in Amsterdam, where procedures appear to be working reasonably well: Paul V. Lemkau and Guido M. Crocetti, "The Amsterdam Municipal Psychiatric Service," *American Journal of Psychiatry*, Vol. 117, 1961, pp. 779-786. The implementation appears straightforward; however, Amsterdam is not Nevada and the procedures may or may not be transferable.

Collaborative efforts between Vancouver's public health nurses and psychiatrists were found effective in reducing the lag time; transfer of the experience to Nevada is problematic. See M. Albert Menzies, "Preventive Psychiatry: The Psychiatric Team as Consultant to the Public Health Nurse," *Canadian Medical Association Journal*, Vol. 93, October 2, 1965, pp. 743-747.

¹⁸ Interview with J. Mikawa, Suicide Prevention and Crisis Call Center, Reno, Nevada, April 23, 1974.

¹⁹ Ibid.

²⁰ "Potential Suicides Prevented," *Las Vegas Review Journal*, May 31, 1975; "Community Service Directory," Voluntary Action Center of Greater Las Vegas, October 1, 1973, pp. 27, 64.

²¹ M. B. Smith, "The Revolution in Mental Health—A Bold New Approach?" *Transaction*, Vol. 5, 1968, pp. 19-23.

²² According to Felice Perimutter, reporting on her investigation of this matter in 1974, "The practice of prevention activity in community mental health centers appears to be inadequately and inconsistently developed on an unplanned, crisis-oriented basis." "Prevention and Treatment: A Strategy for Survival," *Community Mental Health Journal*, Vol. 10, No. 3, 1974, pp. 276-281, at p. 276.

Mandating prevention in the CMHC program nationwide did not facilitate matters—it merely raised legislative and public expectations and heaped yet another service responsibility on the fledgling CMHCs. Trying to satisfy the mandate, consultation and education units were ordered by the National Institute of Mental Health (NIMH) to prevent mental disorders.²³ The order is all the more mystifying when one considers the persistent paucity of NIMH research programs specifically focused on preventive issues. Despite the fact that the study of prevention is a part of NIMH's legal mandate,

There is an obvious need for coordination of activities and effective communication between the different components of the Institute. Research is unevenly distributed amongst the range of possible preventive techniques.

There is a lack of hard conceptualization and no evaluation of decisionmaking in regard to where research might be most useful.

There are only a relatively few staff members who are interested in prevention and have any understanding of the nature of preventive techniques.

A prime need is for research to investigate whether it is possible to establish some of the claims in regard to prevention. . . .²⁴

The point is that national leadership is absent. It is no wonder that, nationally, the preventive dimension of the consultation and education units of CMHCs have floundered,²⁵ or that Nevada's prevention services for mental health disorders have had little success.

Characteristic practices identified as secondary prevention include counseling for people who are grappling with one of life's many crises, such as death of a family member, serious illness, handicaps, accidents, and economic deprivation; helping people resolve problems of interpersonal relations (husbands and wives, parents and children, bosses and workers, and so on); and identifying "developmental" and "situational" conflicts early enough that appropriate treatment can be pursued (the distinction between *treatment* and *prevention* blurs at this point).

The problem from a policymaker's viewpoint, with all of these possible secondary prevention practices, is exceedingly complex. Which practices are the more effective? Which ones even work? The lack of data poses fundamental difficulties not to be resolved in this or any other analysis. All that can be responsibly said is that any or all of these practices may contribute to a reduction in the incidence and prevalence of mental health disorders.

Allocating scarce resources, the practical matter at hand, is of course related to one's priorities and objectives. We believe there are more demonstrably effective ways for Nevada to spend money than on additional primary and secondary prevention of mental health disorders, important though that is. Consequently, we have no recommendations for additional expenditures in this area.

²³ *Consultation and Education: A Service of the Community Mental Health Center, National Institute of Mental Health, Washington, D.C., 1968.*

²⁴ NIMH Research Task Force, Study Group on Treatment Techniques, *Report to the Director, NIMH, Vol. 8, Washington, D.C., 1973, p. 103* (mimeograph). According to the same source, NIMH expends no more than \$3 million per year on prevention, and these funds are not concentrated in the programs of the Institute, but spread throughout (p. 90).

²⁵ A. I. Levinson and S. E. Raff, "Community Mental Center Staffing Patterns," *Community Mental Health Journal, Vol. 6, 1970, pp. 116-126.*

Because tertiary prevention is directed toward "treatment and rehabilitation," there is no practical difference between it and services discussed in other sections of this report. We note that some of our recommendations, later in this report, such as those for improving the identification of people with mental health disorders and for improving the service capacity of the mental health service system, will enhance early treatment of mental health disorders and hence improve tertiary prevention.

PREVENTION OF MENTAL RETARDATION

The parameters used to identify a person as mentally retarded relate to assessments of subnormal intelligence and the person's adaptive behavior at each state of the lifespan (see Chap. 3). Evidence indicates that one's IQ is somewhat modifiable, considerations of testing fidelity and even reliability aside; one's adaptive behavior or level of functioning in society is even more subject to adjustment by the provision of services such as special education and training (a form of tertiary prevention discussed in Chaps. 7 and 11).²²

There are some data on the more than 200 identified specific causes of mental retardation, but these are far from complete, either as to prevalence for any specific disorder or for comprehensiveness among disorders. Metabolic errors, genetic anomalies, drug abuse, environmental pollution, radiation of pregnant women, infections, accidents, improper nutrition, and even the accelerating capacities of the medical system to sustain life have all at one time or another been implicated as causative elements in mental retardation. Societal conditions affecting behavioral adaptation are also related to mental retardation, but the data on the nature and extent of the relationships are poor.

The data presented in Table 5.2, however, are at least suggestive of proportionate distributions among causative etiologies. As noted in the table, 32.2 percent of the new patients were diagnosed as "Uncertain cause—functional reaction alone manifest"; and an additional 16.9 percent were diagnosed as "Unknown cause—structural reactions manifest." In other words, the retardation of 49.1 percent of the new patients in mental retardation clinics who were medically classified had *uncertain or unknown causes*. It appears that research is needed into possible ways of improving basic data collection on the reasons for patients' mental retardation and in time into the basic causes of retardation itself.

When the generic categories of causation are further broken down into the specific medical classifications, we find that the largest group ("Uncertain causes—functional reaction alone manifest") breaks down principally into the vague and unilluminating categories of "Other," 13.3 percent, and "Cultural familial," 8.78 percent. For the second most prevalent generic classification, "Prenatal influence," congenital cerebral defects were the most often reported, at a total of 9.76 percent, and mongolism (Down's Syndrome) was second at 8.15 percent. The "Other" category, which is the most prevalent under "Unknown cause—structural," is also unil-

²² George Tarjan et al., "Natural History of Mental Retardation: Some Aspects of Epidemiology," *American Journal of Mental Deficiency*, Vol. 77, 1973, pp. 369-379, contend that as many as two-thirds of the mildly retarded adolescents and young adults lose their identification as retarded people through adaptation or retesting, or both.

Table 5.2

NUMBER AND PERCENT OF MENTALLY RETARDED NEW PATIENTS IN MENTAL
RETARDATION CLINICS IN THE UNITED STATES BY MEDICAL CLASSIFICATION
AND SUBGROUP, FY 1971

Primary Medical Diagnosis of Condition Causing or Associated with Mental Retardation	Patients	
	Number	Percent
Total mentally retarded	13,744	100.00
Infection	851	6.19
Prenatal infection	372	2.71
Postnatal cerebral infection	479	3.49
Intoxication	440	3.20
Toxemia of pregnancy	163	1.19
Other maternal intoxications	51	0.37
Bilirubin encephalopathy (Kernicterus)	120	0.87
Post-immunization encephalopathy	14	0.10
Other	92	0.67
Trauma or physical agent	1,611	11.72
Prenatal injury	192	1.40
Mechanical injury at birth	291	2.12
Anoxemia at birth	792	5.76
Postnatal injury	336	2.44
Metabolism, growth, or nutrition	517	3.76
Cerebral lipoidosis, infantile	18	0.13
Other disorders of lipid metabolism	24	0.17
Phenylketonuria	142	1.03
Other disorders of protein metabolism	33	0.24
Galactosemia	16	0.12
Other disorders of carbohydrate metabolism	27	0.20
Arachnodactyly	6	0.04
Hypothyroidism	73	0.53
Gargoylism (Lipochondrodystrophy)	31	0.23
Other	147	1.07
New growths	182	1.32
Neurofibromatosis	85	0.62
Trigeminal cerebral angiomas	10	0.07
Tuberous sclerosis	59	0.43
Intracranial neoplasm, other	28	0.20
Prenatal influence	3,397	24.72
Cerebral defect, congenital	989	7.20
Cerebral defect, congenital associated with primary cranial anomaly	352	2.56
Laurence-Moon-Biedl syndrome	9	0.07
Mongolism	1,120	8.15
Other	927	6.74
Unknown cause—structural reactions manifest	2,318	16.86
Diffuse sclerosis of brain	40	0.29
Cerebral degeneration	39	0.28
Prematurity	866	6.30
Other	1,371	9.98
Uncertain cause—functional reaction alone manifest	4,430	32.23
Cultural-familial	1,207	8.78
Psychogenic, associated with environmental deprivation	585	4.26
Psychogenic, associated with emotional disturbance	554	4.03
Psychotic (or major personality) disorder	279	2.03
Other	1,805	13.13

SOURCE: U.S. Department of Health, Education, and Welfare, *Mental Retardation Clinic Services, 1971*, Maternal and Child Health Service, 1972.

luminating. In the "Trauma" category the most frequently reported cause, at 5.76 percent, was anoxemia at birth (subnormal oxygenation of the arterial blood).

Putting aside the difficulties in counting the exact extent of retardation due to specific causes, one may still gain insight about preventive initiatives by considering certain disorders or biological processes that do in fact cause retardation. However, since no one knows conclusively exactly how much retardation is "caused" by various classes of disorders, we do not have much guidance to inform decisions about the allocation of preventive resources among disorder classes. The best one can say at the moment is that certain disorders are known major causes of mental retardation, and that programs to combat them will probably reduce the incidence of retardation in the population.

The literature repeatedly cites four major causative factors of mental retardation, around which the following discussion is organized:²⁷

- Genetic disorders
- Maternal and child health factors
- Malnutrition and undernutrition
- Societal-environmental influences

Genetic Disorders

Genetic diseases and disorders account for a significant but imprecisely known share of the mentally retarded population. Many exciting preventive therapies are being devised, stemming largely from recent major discoveries about the nature of genetic structure and process,²⁸ but direct and widespread application of this knowledge is still years away. Cystinosis, Wilson's Disease, Tay-Sachs Disease, and many others may one day be conquered through careful modification of the afflicted person's enzymatic processes or through sophisticated transplant procedures; however, the state of knowledge and related technology are such as to counsel against premature attempts. It is important for those providing mental retardation care to keep abreast of developments in these rapidly changing and improving fields.

The following discussion takes up three major activities in the prevention of genetic disorders: genetic counseling and associated practices; Rh immunization; and phenylketonuria (PKU) screening and treatment.

Genetic Counseling. Carriers of genetic disorders comprise a small but significant proportion of the general population.²⁹ For example, the genes for PKU and other "in-born errors of metabolism" are carried by some 3 percent of the population.³⁰ Genetic knowledge has been translated into both primary and secondary

²⁷ Our discussion is adapted from Michael J. Bagab, "The Major Dilemma of Mental Retardation," *American Journal of Mental Deficiency*, Vol. 78, No. 5, 1974, pp. 519-529. It is an excellent, thoughtful, and concise treatment of the major issues.

²⁸ James Watson, *Molecular Biology of the Gene*, W. A. Benjamin, New York, 1965; and idem, *The Double Helix*, Atheneum, New York, 1968.

²⁹ W. Roy Breg, "Genetic Aspects of Mental Retardation," *Quarterly Review of Pediatrics*, Vol. 17, 1962, pp. 9-23.

³⁰ Robert Guthrie and Stewart Whitney, *Phenylketonuria: Detection in the Newborn Infant as a Routine Hospital Procedure*, U.S. Department of Health, Education, and Welfare, Children's Bureau Publication No. 419, Washington, D.C., 1964; and V. Elving Anderson, "Genetics in Mental Retardation," in Harvey A. Stevens and Rick Heber (eds.), *Mental Retardation: A Review of Research*, University of Chicago Press, Chicago, Illinois, 1964, pp. 348-394.

preventive methods for parts of this group, although difficulties remain with applications of these methods.

Genetic counseling is a potentially important form of prevention in mental retardation, but will demand much careful thought and both human and capital investment.²¹ Counseling includes informing prospective parents of the probable odds that they will have an abnormal child. A problem is that such counseling can be given realistically only to potential parents in families that already have a history of abnormal children. The counseling can occur before pregnancy and hence influence the decision to conceive the child, or after pregnancy has begun, when diagnostic procedures can provide specific information about certain types of genetic disorders. For a few disorders, e.g., Tay-Sachs and galactosemia, there are straightforward diagnostic procedures; others demand very sophisticated equipment and personnel. It nearly goes without saying that screening and counseling of possible carriers of genetic disorders must be simple, inexpensive, and reliable to warrant large-scale application efforts. "To the extent that groups of women vulnerable to genetic disease can be identified, screening becomes feasible and prevention possible."²²

Several disorders are detectable in the unborn fetus with *in utero* assessment techniques, but realizing the full preventive potential depends upon the accessibility of an up-to-date preventive diagnosis and care program, genetic counseling, and the decision on the part of the parents regarding the desirability of terminating a pregnancy when a genetic disorder is actually detected. (Relatively safe techniques (amniocentesis) exist for sampling amniotic fluid from the sac surrounding the unborn fetus. No one has devised a safe technique for sampling fetal blood, but when this happens, a larger number of genetically related disorders will become likely candidates for *in utero* detection.)

Down's Syndrome is an important causative category in mental retardation, occurring in about one in every 600 babies.²³ Its prevention through family planning and *in utero* assessment (amniocentesis) is within the limits of available knowledge. We know certain characteristics of the population most likely to have Down's Syndrome or mongoloid children. Table 5.3 shows the relationships between the age of the mother, birth order, and the likelihood of a pregnancy resulting in mental impairment.

H. A. Lubs and F. H. Riddle have conducted a detailed epidemiological study which indicates that some 1 to 2 percent of the children born to women over 35 years of age will have chromosomal malformations, and Down's Syndrome is predominant among these.²⁴ Women over 35 account for only about 13 percent of all pregnancies, and yet they have nearly half of all Down's Syndrome children.²⁵ Women under 20 also produce a disproportionately large number of Down's-related mentally retarded children.²⁶ The use of prenatal diagnostic procedures, such as amniocentesis, for

²¹ Robert W. Day, "Genetic Counseling and Eugenics," in Irving Phillips (ed.), *Prevention and Treatment of Mental Retardation*, Basic Books, New York, 1966, pp. 192-196.

²² Begab, "The Major Dilemma," p. 523.

²³ National Association for Retarded Citizens, *Facts on Mental Retardation*, Arlington, Texas, 1973.

²⁴ "Chromosomal Abnormalities in the Human Population: Estimates of Rates Based on New Haven Newborn Study," *Science*, Vol. 166, 1970, p. 466.

²⁵ Begab, "The Major Dilemma," p. 523.

²⁶ Robert W. Day and Stanley W. Wright, "Down's Syndrome at Young Maternal Ages: Chromosomal and Family Studies," *Journal of Pediatrics*, Vol. 66, 1965, pp. 764-771.

Table 5.3

BIRTH ORDER AND MATERNAL AGE AS FACTORS
IN MENTAL DEFICIENCY

Birth Order	Ratio of Observed to Expected (Percent)	Maternal Age	Ratio of Observed to Expected (Percent)
1	52	Under 20	121
2	92	20-24	95
3	135	25-29	88
4	145	30-34	95
5	268	35 and over	146

SOURCE: *American Journal of Mental Deficiency*,
Vol. 60, January 1956, pp. 557-569.

these two at-risk groups would allow the parents to make informed decisions concerning therapeutic abortion, and depending on those parental decisions, could reduce the incidence of mongolism significantly.⁸⁷ We stress that we are not taking a stand for or against abortion, which is a matter for parental and legal decision.

Detecting chromosomal abnormalities *in utero*, and other revolutionary advances in diagnostic procedures, demand sophisticated laboratory facilities most likely to be provided in modern medical centers. Genetic counseling is highly useful today in preventing mental retardation; it will become even more useful as new diagnostic techniques are developed, including the taking of fetal blood and tissue cultures for chromosome morphology.⁸⁸

Experience with a national genetic screening program to detect sickle cell anemia has shown that the underlying intentions of those running the programs are not necessarily shared by those being screened and that the unanticipated, and frequently negative, consequences of the program bear some serious consideration.⁸⁹

- Mass screening had indicated the need to resolve a number of issues related to public education, community relations, and the private lives of the identified trait-carriers.
- The identified individual's reactions are not always positive and favorable.
- Community resistance is commoner and far greater than any of those responsible for the program had expected.
- There is a real danger that those identified as carrying the trait will be stigmatized.
- The eugenic implications of the entire program loom large and are far from being resolved.

⁸⁷ One of the more authoritative sources on these issues is Aubrey Milunsky, *The Prenatal Diagnosis of Hereditary Disorders*, Charles C. Thomas, Springfield, Illinois, 1973.

⁸⁸ The current *International Directory, Genetic Services*, The National Foundation—March of Dimes, White Plains, New York, 1971 ed., lists some 680 genetic service units throughout the United States and Canada, a four-fold increase over the previous five years.

⁸⁹ Barbara J. Culliton, "Sickle Cell Anemia: National Program Raises Problems as Well as Hopes," *Science*, Vol. 176, 1972, pp. 283-286.

Other reports on genetic screening programs have similar messages.⁴⁰ For example, Leonard, Chase, and Childs have reported on a study sample of parents who had previously produced children with cystic fibrosis, phenylketonuria, and Down's Syndrome (the last two are causes of mental retardation). After receiving genetic counseling, only about half the parents had "a good grasp of the information given, 1/4 gained something, and 1/4 learned very little."⁴¹ The amount of information the parents absorbed appeared to be related to the individual physicians who participated in the counseling program, among other factors. The information level attained by parents is critical in determining whether and how they will use their information in making decisions about having additional children. Their predicament is often made all the more difficult by religious concerns, emotional conflicts between the parents, and parents' lack of understanding of genetics and the practical significance of probabilities associated with having handicapped offspring.

The general issue of genetic screening and counseling represents a clear instance of medical knowledge having outpaced the society's ability to accept, use, and cope with the knowledge.⁴² Many people, fortunately, are becoming concerned with some of the implications.⁴³

Genetic counseling is still at an embryonic stage of development in Nevada. In the public sector, the two state Special Children's Clinics provide genetic counseling and testing to a limited number of people, and the 1975 legislature has approved the hiring of a geneticist by the Nevada Mental Health Institute.

In addition, the March of Dimes has funded a very small genetic clinic in Las Vegas for about three years. A clinician from California flies to Las Vegas monthly to meet with patients who have been found and referred by public health nurses. This small effort is being carried out in conjunction with other clinical programs at the Southern Nevada Memorial Hospital and costs the March of Dimes about \$400 monthly. The program is a worthwhile beginning. It contains other desirable preventive aspects, e.g., a birth defects registry, and training of Nevada physicians in principles and applications of neonatology. However, it is only a beginning; it is being done on a shoestring with private "seed money" of uncertain duration. The total expenditures in all three genetic programs noted above probably approximate \$75,000 per year. The March of Dimes in northern Nevada has planned and funded another genetic clinic in Reno, similar to the one in Las Vegas, and the first of four clinics to be held each year will be in April 1976. We do not know the extent of

⁴⁰ Hans Zellweger, "Genetic Counseling in Clinical Medicine," *Modern Medicine*, October 9, 1967, pp. 40-52.

⁴¹ Claire O. Leonard, Gary A. Chase, and Barton Childs, "Genetic Counseling: A Consumer's View," *New England Journal of Medicine*, Vol. 287, No. 9, August 31, 1972, pp. 433-439, at p. 433.

⁴² Public education may be especially critical in this regard. See, for example, Ellen Beck et al., "Advocacy and Compliance in Genetic Screening," *New England Journal of Medicine*, Vol. 291, No. 22, November 28, 1971, pp. 1166-1170.

⁴³ Marc Lappé et al., "Ethical and Social Issues in Screening for Genetic Disease: A Report from the Research Group on Ethical, Social, and Legal Issues in Genetic Counseling and Genetic Engineering of the Institute of Society, Ethics, and the Life Sciences," *New England Journal of Medicine*, Vol. 286, May 25, 1972, pp. 1129-1132. Lappé et al. have mapped the roughest contours of the hazardous terrain confronting society in this general area. Before any genetic program is undertaken, serious contemplation of the various messages contained in that document are warranted. Other important sources on this topic include J. R. Sorenson, *Social Aspects of Applied Human Genetics*, Harvard University Press, Cambridge, Massachusetts, 1971; F. C. Fraser, "Genetic Counseling and the Physician," *Canadian Medical Association Journal*, Vol. 99, 1968, pp. 927-934; and C. O. Carter et al., "Genetic Clinic: A Follow-Up," *Lancet*, No. 1, 1971, pp. 281-285.

genetic counseling by physicians for their private patients in Nevada, but some such counseling probably exists.

Private physician screening for genetic disorders, such as Down's Syndrome, using amniocentesis may be occurring in Nevada, but we are unaware of the extent of it. There are reasons for less than optimal employment of this important technique; they include basically technical matters, e.g., some physicians who are untrained in the technique, inadequate equipment and facilities in some areas, and moral issues underlying much of the debate on therapeutic abortion.⁴⁴

Were a genetic screening, counseling, and diagnosis service to exist, the need for decisions on therapeutic abortion would be an obvious consequence of true positive identifications through amniocentesis, chromosomal morphology, or other assessment techniques yet to be developed and perfected. While recent court decisions have helped to clarify the issue of abortion as a medical practice, the case is far from closed. In an assessment of the practice made in 1969, Beck and her associates stressed that many important research issues remain to be resolved, several of which have clear policy implications.⁴⁵ The discussion and the research issues appear to merit continuing serious consideration.

Sterilization as a family planning practice to prevent handicapping is, if anything, an even more controversial subject—a point underacored in recent revisions and clarifications of Department of Health, Education, and Welfare guidelines on the practice in federally funded programs.⁴⁶

Recent sensational revelations to the effect that parents and pediatricians in charge of an infant intensive-care unit at the Yale-New Haven Hospital had given some 43 seriously deformed and impaired infants what some journalists have called the "right to die," deserve mention as perhaps the logical and moral limit in preventive strategies.⁴⁷ The magnificent lifesaving technologies that medical science has produced in the last decade or so have brought with them moral and ethical questions that demand full and humane inquiry. Should a seriously impaired infant, who is in need of extensive medical treatment to maintain life, be allowed to die? Bound up in this chilling question are other imponderable issues: What constitutes "seriously impaired?" Will improved technology and increased public awareness of population growth problems force this definition to change over the years, to the point where a "minor impairment" by 1975 standards becomes a "serious impairment" by the standards of some decades hence? Who is to decide when the child's life should cease to be supported by medical treatment? How is one able to certify that the child's "right to life" has not been violated? These issues are upon us and demand attention.

Rh Immunization. Development and use of the Rh desensitizing gamma

⁴⁴ Amitai Etzioni, a sociologist and an authority on genetic issues, announced at the recent annual meeting of the American Association for the Advancement of Science (New York, January 1975) that results of a national survey of obstetricians/gynecologists indicated that over half would not use these techniques, even with pregnant patients over age 40. He stated that the primary reasons were related to medical conservatism about adopting new practices and techniques.

⁴⁵ "Right to Life" proponents of course oppose the concept and practice on principle. See Mildred B. Beck et al., "Abortion: A National Public and Mental Health Problem—Past, Present, and Proposed Research," *American Journal of Public Health*, Vol. 69, December 1969, pp. 2131-2143.

⁴⁶ "Doctors Scored on Sterilization," *New York Times*, October 31, 1973.

⁴⁷ The disclosure has attained widespread public attention. See, for example, "43 Deformed Infants Given 'Right to Die'," *Los Angeles Times*, October 27, 1973. One can only guess at the extent of the practice elsewhere in the United States.

globulin has reduced jaundice in the newborn and thus has also reduced incidence of the associated mental disorder, kernicterus. To prevent sensitization and subsequent threat to additional children, however, the RhoGAM must be administered within 72 hours after the Rh-negative mother has terminated pregnancy of an Rh-positive child. Blood-typing and antibody screening are considered an important part of effective prenatal care; and depending on the bilirubin levels obtained in amniocentesis (when indicated), specific management procedures of mother and unborn child may be required.⁴⁸ Immunization, typing, screening, evaluation, and management are all elements of responsible preventive care. The extent of the reduction in handicapping conditions resulting from this kind of care is not known, but is clearly positive.

RhoGAM therapy to desensitize blood-incompatible mothers is a matter of routine practice in most obstetric services in modern hospitals; however, it is not known whether coverage of the practice extends to all areas of Nevada.

Phenylketonuria (PKU) Screening and Treatment. An example of a retardation-causing etiology that has yielded somewhat to secondary preventive measures is phenylketonuria (PKU).⁴⁹ Prevention in this case is pointed toward early detection; infants are screened by means of urine tests⁵⁰ and by a newer and more satisfactory test (the Guthrie Inhibition Assay) for elevated serum phenylalanine.⁵¹ The latter test has been found superior for the following reasons:⁵²

- More reliable test results, i.e., fewer false negative results.
- Earlier diagnosis (within the first three days of life) than with urine tests.
- Better chances that all children will be tested than with urine tests (which may miss symptoms in children who do not manifest them in urine for as long as several weeks after birth, when they have gone home).

Such screening has been shown to be decidedly cost-effective, despite the low incidence of the disorder.⁵³

The disease is hereditarily transmitted—an error of metabolism—and may be treated and “prevented,” if detected early enough, through a carefully controlled dietary regime. Untreated, PKU almost without exception results in mild to severe retardation, including a predisposition to seizures and assorted medical anomalies.

Even here, however, prevention is not a certainty. Opinions differ, ranging all

⁴⁸ J. T. Queenan, *Modern Management of the Rh Problem*, Harper Medical Division, Baltimore, Maryland, 1967.

⁴⁹ S. I. Goodman, “Some Advances in the Prevention of Mental Retardation,” in Irving Schulman (ed.), *Advances in Pediatrics*, Vol. 2, Year Book Medical Publications, Chicago, Illinois, 1972.

⁵⁰ Including the ferric chloride test, the diaper test, the filter paper test, the Phenistix test, and the chromatographic test.

⁵¹ Described in Guthrie and Whitney, *Phenylketonuria*.

⁵² David Hais et al., “Screening Newborn Infants for Phenylketonuria,” *Journal of the American Medical Association*, Vol. 188, 1964, pp. 203-208; a standard, but thorough, summary is contained in F. L. Lyman (ed.), *Phenylketonuria*, Charles C. Thomas, Springfield, Illinois, 1963, Chap. 7.

⁵³ Massachusetts and Delaware, to cite only two states where analyses of PKU programs have been published, have had important and positive experiences. Massachusetts Department of Public Health, “Cost-Benefit Analysis of Newborn Screening for Metabolic Disorders,” *New England Journal of Medicine*, Vol. 291, No. 26, December 28, 1974, pp. 1414-1416. The Delaware experience is reported in “State-Federal Spotlight,” *Insight*, April 1975, p. 2, where the following claim is made: “To date [since 1962] 118,000 babies have been tested, and eight infants who were found to have the rare condition were placed on special diets . . . The tests cost about \$6000 per year (and it was noted) if the eight babies had gone untested and spent their lives in institutions for the mentally retarded, the cost to the state would have been \$500,000 for each child.”

the way from those who claim that the disease can be eradicated with adequate screening, diagnosis, and early treatment, to those who question both screening procedures and the efficacy of the treatments.⁵⁴

Evidence has been presented suggesting that there may be some preventive potential, easily overlooked, to be gained by testing older children. Dietary treatment has significantly increased the IQ of children as old as 8 who were found to suffer from PKU.⁵⁵

Finally, because it is genetic in origin, and both parents must carry the gene, a number of primary preventive measures could be considered. They include establishing local PKU registers for use in genetic counseling programs, and testing mothers of retarded children during subsequent pregnancies for elevated serum phenylalanine levels.⁵⁶

Testing for PKU is also a staple of good medical practice, and its preventive potential is excellent. In accord with Nevada law, testing for PKU is supposed to occur routinely for newborns.

Newborn screening for a number of other extremely low-incidence metabolic disorders leading to mental retardation is within the realm of technical feasibility. However, there are a large number of known, possible causative etiologies,⁵⁷ as well as "uncertain causes"; most are of extremely low incidence; and aside from Down's Syndrome, PKU, and Rh sensitization, most others are not the subject of widespread screening by physicians. In fact, many are as yet outside the capability of all but the best-equipped and staffed medical research centers.⁵⁸ Cautions about expanding screening programs to other disorders have been stressed by Efron (and others) in the following terms:

Screening programs have thus enormously increased both our knowledge and our awareness of our ignorance. The experience with massive PKU screening in particular has indicated that we know very little about inborn errors of metabolism. Certainly, the simple concepts which were the basis of the compulsory legislation for PKU are open to question. It is hoped that we can pursue our course of investigation of the other inborn errors of metabolism without imposition of compulsory screening programs which necessarily lead to treatment by inexperienced persons and which necessarily imply that there is an effective 'tried and true' therapy which must be administered as soon as the diagnosis is made. Our state of knowledge about the best treatment for these disorders is as primitive as that about the pathophysiology of the diseases.⁵⁹

Maternal and Child Health Factors

Prematurity and low birth weight are known to be highly associated with men-

⁵⁴ E. Daren et al., "Statement on Treatment of Phenylketonuria," *Pediatrics*, Vol. 35, No. 3, 1965, pp. 501-503.

⁵⁵ A. Moncrief, "Testing for Phenylketonuria After Infancy," *British Medical Journal*, Vol. 1, No. 5441, 1965, pp. 1065-1066.

⁵⁶ R. W. Coffelt, "Unsuspected Findings From a PKU Newborn Screening Program," *Pediatrics*, Vol. 34, No. 6, 1964, pp. 889-890.

⁵⁷ Milunsky, *Prenatal Diagnosis*, contains a comprehensive listing of the possibilities.

⁵⁸ It should be noted, however, that the Massachusetts screening program routinely detected very-low-incidence metabolic disorders in addition to PKU; adaptation and adoption of that program in other settings could have similarly advantageous effects. Our general cautions on the need for high-quality staff and equipment remain.

⁵⁹ Mary L. Efron, "Metabolic Factors in the Prevention of Mental Retardation: Compulsory Screening Legislation Open to Question," *Rhode Island Medical Journal*, April 1967, pp. 255-257, at p. 257.

tal retardation and other disorders. As medical technology has advanced and newborn survival rates have risen, the incidence of mental retardation associated with those factors has risen.⁸⁰ As with nearly all aspects of retardation, the evidence is not uniformly consistent and there is disagreement over precise causal connections and incidence rates. For instance, the observed fact that low birth weight is correlated with race, socioeconomic status, and complications of pregnancy adds confusion to the inquiry into the true causal connection between birth weight and retardation. However, according to one knowledgeable researcher, "From the data it could be deduced that prematurity is hazardous because the immature central nervous system is more subject to damage [than the full-term one]."⁸¹ That view is plainly supported in the literature.⁸² A number of factors have been implicated as responsible for prematurity and low birth weight, and hence primary preventive efforts logically focus on them.

Infectious diseases, anemias in pregnancy, toxemia in pregnancy, viral diseases, toxoplasmosis, mechanical injury at birth, and anoxia have all been singled out for research attention, and success in understanding each represents a hopeful source of reduction in the incidence of retardation.

From the above and related lists of causative agents, it appears that several generalized preventive strategies afford some potential respite. Included are improved prenatal and perinatal health care, family planning, and immunization.

Prenatal and Perinatal Health Care. More is being learned regularly about the critical importance of maternal and child care before, during, and soon after birth as a general preventive strategy. Specific relationships between prenatal conditions and subsequent mental disorders are known,⁸³ while many others are suspected and, given the prevalence of "Unknown prenatal influence" as an etiologic class, have become fitting research topics.

In an informative and concise summary of the "do's and don'ts" for a pregnant woman, Jane Brody has made the following observations, all of which can improve the chances of having a normal baby:

- Most important is the early and periodic prenatal examination by a competent physician. All adverse indicators, e.g., low birth weight, prevalence of defects, and fetal misadventure, are positively related to poor or nonexistent prenatal care.
- Drug intake, including common nonprescription, prescription, and "dangerous" drugs should be sharply curtailed or eliminated altogether. If drugs must be taken, they should be taken only with the guidance and prescription of a physician, preferably the obstetrician responsible for prenatal course of treatment. In this regard, no drug—no matter how "harmless"—is to be considered above suspicion. Definitive research simply has not been done in sufficient quantity to rule out the potentially

⁸⁰ Lula O. Lubchenco et al., "Sequelae of Premature Birth: Evaluation of Premature Infants of Low Birth Weights at Ten Years of Age," *American Journal of Diseases of Children*, Vol. 108, 1963, pp. 101-115, assert that IQ is directly related to birth weight.

⁸¹ Harry A. Waisman, "Recent Advances in Mental Retardation," in Philips, *Prevention and Treatment*, pp. 125-144, at p. 127.

⁸² A representative review and sampling of which is contained in D. V. Caputo and W. Mandell, "Consequences of Low Birth Weight," *Developmental Psychology*, Vol. 3, 1970, pp. 363-383.

⁸³ A. Zitrin et al., "Pre- and Perinatal Factors in Mental Disorders of Children," *Journal of Nervous and Mental Diseases*, Vol. 130, 1964, pp. 357-361.

damaging effects of any drug or foreign chemical substance, and this includes aspirin, nicotine, caffeine, and vitamins taken in excessive amounts, as well as prescription medications such as steroids, progesterone, antibiotics, diuretics, antihistamines, and antidepressants.

- Proper nutrition [discussed separately in the next subsection] is important as part of sound prenatal care; protein deficiencies, for instance, are known to be related to decreased cerebral development.⁶⁴
- Abdominal x-rays should be avoided, especially in the first weeks of pregnancy.
- Live virus vaccines should not be administered if pregnancy is suspected; included in this list are smallpox, measles, rubella, mumps, and yellow fever.⁶⁵

Prenatal and perinatal care are available through private physicians and hospitals, with Medicaid providing some coverage for low-income people. We commend the Maternal and Infant Care Program of Clark County for their efforts to extend these services to low-income families. We understand that several hundred mothers and their children received prenatal care, e.g., examinations, laboratory work-ups, and some medication, during the first six months of 1974. This is not a full-pay program but rather defrays about one-half of the usual prenatal, delivery, and postnatal cost, which is running around \$900 in Clark County. New mothers in this program can be provided with family planning information, and later can participate in an Infant Care Clinic, where the child is periodically examined and receives needed immunizations. Admirable as these initiatives are, the funds backing them come primarily from a soft-money federal grant.

Family Planning. A combination of better family planning and reduced family size is a preventive strategy that is relevant to both mental health problems and mental retardation. Its effects on the overall reduction of handicapping conditions in the population are not to be underestimated, for it has been demonstrated that smaller family size is positively associated with lower fetal, neonatal, and postnatal mortality and morbidity rates; with lower prematurity rates and consequently lower incidence of handicaps such as seizures and cerebral palsy; with more adequate prenatal care and better education for children; with lower incidence of infectious disease in parents and children; with better growth, in both height and weight, among preschool and schoolchildren; and with higher IQ scores.⁶⁶ As we noted earlier, relationships between the likelihood of mental impairment in the infant, the age of the mother, and the total number of children in the family have been established. Family planning in this case has to do with learning in advance the odds of producing a defective child. One may surmise that wider adoption of family planning practices, such as completing the family before the mother reaches age 40, will somewhat reduce mental retardation in the overall population.

Immunization. Immunization is another general strategy to prevent infec-

⁶⁴ See also, *Nutrition and Human Development: A Special Report Prepared for the National Advisory Child Health and Human Development Council*, National Institute of Child Health and Human Development, Washington, D.C., November 17, 1969.

⁶⁵ Jane E. Brody, *How a Mother Affects Her Unborn Baby*, National Institute of Child Health and Human Development, Washington, D.C., 1971 (reprint).

⁶⁶ *Lengthening Shadows: A Report of the Council on Pediatric Practice of the American Academy of Pediatrics on the Delivery of Health Care to Children*, 1970, American Academy of Pediatrics, Evanston, Illinois, 1971, p. 56.

tion-caused mental retardation. Both the National Center for Disease Control, and recent findings of the U.S. General Accounting Office, indicate that significant fractions of children in both central city and rural areas are not being vaccinated against preventable diseases. Of central city children surveyed, for example, it was found that about one-half were not protected against measles or polio. In 1971, more than 75,000 cases of measles (a causative factor in mental retardation) were reported, an increase of 22,000 from the previous year.⁶⁷ It is a persistent problem,⁶⁸ reflecting both the fragmented nature of the health system generally and the particularly limited interest given to preventive measures as contrasted with most other services. It apparently takes an epidemic to force disease prevention into the forefront.

It took a major epidemic in the mid-1960's to galvanize official attention in the case of rubella (a major causative factor in mental retardation and a host of other disorders), but lacking catastrophes on a recurring basis, official attention and activity have waned. Specific details of what this entails for the rubella prevention program include the following:⁶⁹

- There is marked unevenness in the quality of community-run programs and slight provision available to correct the more deficient of these.
- Identification of those at risk is not uniformly well done, with the result that coverage is uneven.
- School-based programs miss many preschoolers.
- Maintenance and surveillance are crudely developed, and "the probability of satisfactory maintenance after federal funding ends is poor."
- Private physicians are not included in the reporting procedures of the program, thereby missing much of the population and reducing the effectiveness of program appraisals.

The importance of preventive medical care has been demonstrated many times,⁷⁰ and we also note that on the grounds of high economic benefits in relation to costs, a prevention program for rubella-caused handicaps through immunization is decidedly worthwhile.⁷¹

Measles is another infectious disease that can cause mental retardation but against which immunization is effective. In about one in every 1000 cases of measles, encephalitis occurs; when it does, it results in death in 10 to 20 percent of the cases

⁶⁷ Reported in *Education Daily*, May 5, 1972, p. 6, where it was noted that both measles and diphtheria have risen sharply since 1970, a finding alleged to be linked to government reluctance to support vaccination programs.

⁶⁸ In June 1974 the General Accounting Office again warned of the likelihood of epidemics because immunization rates had been allowed to fall far below acceptable rates nationally. Specific states were singled out for criticism. *Education Daily*, June 25, 1974, p. 2.

⁶⁹ Bio-Dynamics, Inc., *Evaluation of the Rubella Immunization Program*, Department of Health, Education, and Welfare, Office of the Assistant Secretary for Planning and Evaluation, Contract No. O6-70-153, Washington, D.C., 1972, pp. 6-9, 78-81.

⁷⁰ Donald R. Calvert, *Report on Rubella and Handicapped Children*, Department of Health, Education, and Welfare, Bureau of Education for the Handicapped, Washington, D.C., May 1969; and Garry D. Brewer and James S. Kakalik, "Serving the Deaf-Blind Population: Planning for 1980," in Carl E. Sherrick (ed.), *1980 Is Now*, John Tracy Clinic, Los Angeles, California, 1974, pp. 19-23. Mental retardation, for a variety of reasons, is only one of many factors affecting this tragic population.

⁷¹ See James S. Kakalik, Garry D. Brewer, et al., *Improving Services to Handicapped Children*, The Rand Corporation, R-1430-HEW, May 1974.

and a long lasting central nervous system defect in 33 to 50 percent. About one in 3000 children who have measles will become retarded as a result.⁷²

Other retardation-causing diseases may one day yield to prevention through immunization,⁷³ but at the moment, measles and rubella are positively controllable etiologies. In Nevada, rural children are the most easily overlooked and hence require special efforts to assure that proper immunization levels are achieved and maintained.

The Nevada Division of Health has a Family Planning program with clinics in five counties and services through physicians' offices in the remaining counties. The FY 1975 budget was about \$54,000.⁷⁴ In addition, the Division's Bureau of Community Health Services has a staff of 19 public health nurses who perform a wide variety of services including family planning, prenatal and postnatal maternal counseling, and work in immunization clinics.⁷⁵ The same Bureau has an FY 1975 federal grant of about \$40,000 for a rural immunization clinic program (with public health nurse staffing) to provide polio, measles, rubella, diphtheria, tetanus, and whooping cough immunizations free of charge.

Well-baby clinics are operated in Nevada under District Health Department auspices for children to age 4. These clinics "travel," in the sense that the local public health nurse advertises in advance the locations where she will be available to examine the children and to give immunizations. She is also providing an essential outreach or identification service in this program.

Malnutrition and Undernutrition

There is little doubt concerning the general ill effects of malnutrition and undernutrition, both to pregnant women and to developing children.⁷⁶ Malnutrition studies have concentrated on animals, on follow-ups to starved wartime populations,⁷⁷ and on a few "underdeveloped" countries.⁷⁸ The research results tend to confirm that there is a relationship between malnutrition, socioenvironmental factors, and mental competency. The precise relationships and links are not yet known; as with many other preventive strategies, all that can be said is that an undernour-

⁷² C. Kennedy and T.F.M. Scott, "The Management of Acute Febrile Encephalopathies," in *The Prevention of Mental Retardation Through the Control of Infectious Diseases*, as reported in R. Conley, *The Economics of Mental Retardation*, The Johns Hopkins University Press, Baltimore, Maryland, 1973.

⁷³ Two English physicians, Elek and Stern, have developed a vaccine for cytomegalic inclusion disease, thought to be responsible for as many as one mentally retarded individual per 2000 live births. This viral disease is believed to cause damage to the fetus by transmission through the placenta. The vaccine is new, has been tested on humans, and is presently undergoing final experimental testing. *New York Times*, August 17, 1973.

⁷⁴ Governor M. O'Callaghan, *The Executive Budget, Fiscal Years 1975-76 and 1976-77*, State of Nevada, Carson City, Nevada, January 30, 1975, p. 270.

⁷⁵ *Ibid.*, p. 283.

⁷⁶ *Nutrition and Human Development*; and M. B. Stoch and P. M. Smythe, "Does Undernutrition During Infancy Inhibit Brain Growth and Subsequent Intellectual Development?" *Archives of the Disabled Child*, Vol. 38, 1963, pp. 546-552.

⁷⁷ Z. Stein et al., "Nutrition and Mental Performance," *Science*, Vol. 178, 1972, pp. 708-713; and A. N. Antonov's classic, "Children Born During the Siege of Leningrad in 1942," *Journal of Pediatrics*, Vol. 30, 1947, pp. 250f.

⁷⁸ S. A. Richardson et al., "The Behavior of Children in School Who Were Severely Malnourished in the First Two Years of Life," *Journal of Health and Social Behavior*, Vol. 13, 1972, pp. 276-284 (Jamaica); and J. Hoorweg and Paul Stanfeld, "The Influence of Malnutrition on Psychological and Neurological Development," in *Nutrition, the Nervous System, and Behavior*, Panamerican Health Organisation, Washington, D.C., 1972 (Uganda).

ished mother and her child, all other things being equal, are more likely to have mental handicaps than are well-nourished ones.

Care is needed to insure that economically underprivileged and potentially undernourished segments of the population have adequate food.⁷⁹

In at least one Federal Government project, strong assertions about these matters have been presented:

It has been estimated that 75-85 percent of all mentally defective children are born in a poverty environment. All the statistical data available reaffirm the connection between poverty and malnutrition, between malnutrition and disease. Malnutrition appears to be the common denominator of each of the problems—low birth weight, infant mortality, mental retardation, and intellectual malfunction. Any attempt to break the cycle of poverty characterized by these phenomena must include nutritional intervention, or this wastage of human life will continue unabated.⁸⁰

The report concludes with appeals for nutritional intervention, and does so on cost-effectiveness as well as other grounds. "The total cost of a city's supplemental feeding program—\$100,000-\$500,000—is less than the estimates of lifetime expenses of a few retarded infants."⁸¹

Nutrition is not likely to be a significant problem for those wealthy enough to afford care in the private sector (although malnutrition is known to occur in the middle and upper classes). Nutrition for low-income households is of primary concern in two programs in Nevada: food stamps for low-income households, adding about \$14 million in FY 1975 to their food-purchasing ability;⁸² and the Women, Infant's and Children's (WIC) Food Supplement program for low-income people, funded by the U.S. Department of Agriculture to provide about \$14 per person per month in food supplements to help eliminate developmental problems due to poor nutrition.⁸³

Mental health and mental retardation service programs do not play a major role with nutrition, but the Division of Mental Hygiene and Mental Retardation might be able to foster prevention through public education. It could prepare material describing the relationship between nutrition and handicapping conditions in children, for free distribution through doctors, public health nurses, social workers, and other professionals.

Societal-Environmental Influence

Disputes regarding biologic relationships to mental retardation pale in comparison with those attending societal-cultural-environmental relationships to mental retardation. The debate has gone on long enough to have won the handy label of "the nature-nurture" controversy.

On the one hand, the extreme "naturalist" view is summarized in an oft-cited but timeworn passage of Sarason:

⁷⁹ R. V. Rider, M. Taybeck, and Hilda Knoblock, "Associations between Premature Birth and Socio-economic Status," *American Journal of Public Health*, Vol. 148, 1958, pp. 1022-1028.

⁸⁰ Select Committee on Nutrition and Human Needs, U.S. Senate, *To Save the Children: Nutritional Intervention Through Supplemental Feeding*, 93d Cong., 2d sess., Government Printing Office, Washington, D.C., 1974, p. 47.

⁸¹ *Ibid.*

⁸² Governor O'Callaghan, *The Executive Budget*, p. 363.

⁸³ *Ibid.*, p. 374.

Despite the well-nigh perfect correlation between the garden variety of mental deficiency and unfavorable social conditions, the consensus among workers in the field is that cultural factors are relatively unimportant.⁸⁴

Few would accept this at face value today; but equally few are willing, on the other hand, to accept so extreme a "nurturist" view as that postulated by Perry:

... to prevent the greatest number of cases from ever happening, ... [clinicians] must become concerned with radical changes in our social order ... This order produces mental deficiency by poverty; racial discrimination; tax protection of the advantaged classes ...⁸⁵

We are confronted with a practical problem in deciding where one can responsibly focus attention with an end in view of lessening the incidence of mental retardation through societal-environmental initiatives.

The societal-environmental setting does make some difference, particularly in the lives of the mildly retarded where central nervous system pathologies are not evident.⁸⁶ The unresolved controversy centers on the nature and degree of the societal-environmental contribution to the extent of retardation and the amount of remediation, i.e., prevention, that can be effected on society and the environment and hence on retardation. Improvement in health, education, welfare, housing, nutrition, vocational programs, and other programs for the general population would contribute in some positive but not reliably known degree to the prevention of mental retardation. Conley has calculated that "if all groups in society had the same percentage of persons with IQs below 50 as middle- and upper-class white children, the prevalence of this level of mental retardation would decrease by almost 80%."⁸⁷

Aside from improving these types of programs for the general population, a would-be preventive interventionist has only a few strategic options.⁸⁸

- *Effective family planning* appears to be a worthwhile undertaking, particularly for intellectually subnormal parents, among whose offspring data confirm that retardation does occur with far greater frequency than would be expected purely from chance.⁸⁹
- *Early intervention*, based on the best current knowledge, can improve sensory, language, and problem-solving skills, and aid the full development of basic adaptive behavior.

We described the former strategy earlier with respect to biologic disorders, but the basic functional requisites are similar in this case. What appears to be lacking

⁸⁴ Seymour R. Sarason, *Psychological Problems in Mental Deficiency*, Harper and Row, New York, 1963 ed., p. 134, reproduced in the 1969 ed.

⁸⁵ Stewart E. Perry, "Notes for a Sociology of Prevention in Mental Retardation," in Phillips, *Prevention and Treatment of Mental Retardation*, pp. 145-176, at p. 173.

⁸⁶ Frank Riessman, *The Culturally Deprived Child*, Harper and Row, New York, 1972, is a standard source.

⁸⁷ R. Conley, *The Economics of Mental Retardation*, The Johns Hopkins University Press, Baltimore, Maryland, 1973, p. 323.

⁸⁸ See Begab, "The Major Dilemma," pp. 526-529.

⁸⁹ Rick F. Heber et al., "The Influence of Environmental and Genetic Variables on Intellectual Development," in H. J. Prellun et al. (eds.), *Behavioral Research in Mental Retardation*, University of Oregon, Eugene, Oregon, 1968, p. 8.

at present is a coordinating and guiding institution to implement a needed family planning education and operations program—and to sustain it.

The latter strategy is less well developed in specific relation to the prevention of mental retardation. We are aware of at least one scientifically designed and executed experiment in which intervention of several varieties has been attempted in a controlled setting.⁹⁰ The referenced work is complete with training guides, teaching materials, and several helpful, how-to-do-it appendixes.

Recommendations for Mental Retardation Prevention

Many types of mental retardation can be prevented, including several of the more prevalent types. In 1972, the President of the United States set a national goal of reducing the occurrence of mental retardation by 50 percent by the end of the century. The explosion of knowledge in recent years gives society the potential to make larger inroads into these problems, but many practical difficulties must be overcome in applying that knowledge. PKU-caused retardation is largely preventable through dietary means in children who are found early enough, but not all children are screened properly for PKU. Reliable genetic information for a host of retardation-causing disorders can be provided to parents and prospective parents (e.g., those most likely to have an abnormal child) but social, emotional, and moral problems are associated with this procedure. Society knows how to detect Down's Syndrome in the unborn fetus, but prevention at the fetal stage depends on decisions regarding therapeutic abortion. Immunization can prevent infectious diseases that cause retardation, but many children are not immunized.

Nevada has programs to improve the societal-environmental living conditions for its general population, and offers direct service programs for Nevadans who are already mentally retarded. Those programs can be called tertiary prevention programs in the sense that they work to help mentally retarded people to alleviate or eliminate their functional retardation. Nevada has only a few programs for the direct prevention of mental retardation, however, and they are uncoordinated, highly undeveloped, and not available to all Nevadans in need.

We recommend that specific responsibility for mental retardation preventive services be established within the Department of Human Resources (perhaps in combination with the new unit for direction services recommended in Chap. 4), whose functional responsibilities would include the following:

- *Coordination, monitoring, and assessment of ongoing preventive services for mental disorders.*
- *Leadership in the creation of new preventive services where needed in Nevada and as warranted by advances in new knowledge throughout the United States.*

We are not saying that these personnel assigned overall responsibility for prevention should operate all prevention programs, since some reside appropriately within various state agencies; rather, we are saying that preventive efforts need to be coordinated, and someone needs to take responsibility for guiding the building of a

⁹⁰ Rick F. Heber et al., *Rehabilitation of Families at Risk for Mental Retardation*, University of Wisconsin, Rehabilitation Research and Training Center in Mental Retardation, Madison, Wisconsin, 1972.

high-quality system of preventive services in Nevada. The present scattered responsibility, or lack of assigned responsibility, appears to be one of the prime reasons for underdevelopment of preventive services in the state. Initial activity could include making a survey of all existing preventive services for mental retardation and prenatal and perinatal health, followed by publication and updating of a handy, easy-to-read guide to these services for use by private physicians, parents, volunteer groups, and others.

We recommend expanded genetic testing and counseling capabilities, accompanied by the creation of a high-risk registry, for parents and potential parents of mentally retarded children. We stress that genetic testing and counseling would be provided on a voluntary basis; the intention is not to tell families what to do, or to offer value judgments on a family's decisions, but to provide them with information they can use in arriving at their own decisions to conceive and bear children. These capabilities should be provided by two full-time teams in the Reno and Las Vegas areas, with provisions for service to people in rural areas. Funding should be on a stable basis. The creation of a high-risk registry (with information and direction-like referral built in) would help make genetic counseling available to those most likely to benefit from it. The registry could include, among others, pregnant women over 35 and under 17, and families with a history of a retardation-causing metabolic disorder or an inherited genetic disorder capable of causing mental retardation. The various medical, mental retardation, and special education programs in the state would serve as excellent sources of referrals.

Conley has conducted a detailed economic benefit-cost analysis of amniocentesis for the detection of Down's Syndrome children, comparing the cost of testing and prevention with the lifetime service costs. He found that screening the entire population is not justified on an economic basis alone, but that testing of high-risk groups yields economic benefits that clearly outweigh the economic costs.²¹

We recommend implementation of monitoring and enforcement mechanisms to help ensure that all newborn children are screened for PKU, that Rh desensitization is provided when needed, and that all children of early school-age are immunized against handicapping infectious diseases. PKU screening, Rh desensitization, and immunization for measles and rubella are effective and economically justifiable in helping prevent mental retardation and other handicapping conditions. In accord with Nevada law, PKU screening is supposed to occur routinely for newborns. These preventive services are relatively well provided in Nevada, but mechanisms are needed to insure that coverage of the subject populations is as nearly universal as possible. Specifically with regard to rubella, we recommend:

- Vaccination for all prepubescent females.
- The creation of a model code for state marriage license serologic screening practices, with the objective of including a test for the presence of rubella antibodies.
- An appeal through the mass media and professional associations to encourage all childbearing females to obtain such tests from their private physicians. The decision to proceed with vaccination, in those not naturally immune, then becomes a uniquely determined one between doctor and patient.

²¹ Conley, *The Economics of Mental Retardation*, pp. 312-315.

These recommendations are fully detailed in our previous work for the Secretary of Health, Education, and Welfare,²² but the following is illustrative of what might be involved for Nevada.

There being about 10,000 children of each single year of age in Nevada (see Chap. 3), it would take about 5000 vaccinations a year to reach the entire female at-risk population on an annual cohort basis. At vaccine costs of 50¢ per dose,²³ total vaccine costs would be around \$2500 per year in the steady state case. With the cost of administering the vaccine (say \$5 per child) the total annual cost would be about \$27,500. In contrast, merely educating one child retarded because of rubella costs approximately \$32,000 for a full 13-year special education program (see Chap. 7).

In the time period immediately following birth of a child, we recommend the provision of family planning information to parents, plus creation of a registry and follow-up for children born abnormal or at high risk of being mentally retarded or having some other handicap. The registry and follow-up for high-risk children would be especially valuable in permitting early detection of retardation or other handicaps, so that preschool special education and training and other services (tertiary prevention) could begin at an early age. The Southern Nevada Special Children's Clinic has a pilot project underway in conjunction with the Sunrise Hospital to develop a registry and follow-up for children born abnormal or at high risk.

With respect to good prenatal and perinatal medical care, a clear positive factor in preventing retardation, the main question is how to secure such care for pregnant women and new mothers if they are not receiving it. One can envision increased outreach by public health nurses and others to women who are not likely to seek good prenatal health care, and to women who do not return for routine and periodic checkups of their babies. Perhaps the largest improvement, however, would come from lowering financial barriers to good medical care. The state, for example, might consider requiring that private insurance carriers cover prenatal and perinatal care fully, without deductibles, including coverage of the child from the moment of birth.

PREVENTION OF ALCOHOL AND DRUG ABUSE

Unlike many mental health problems, alcohol and drug abuse often involves a volitional component, at least insofar as a person decides to drink or use drugs in the first place and often decides when and how often to do so. For this reason prevention programs may well have important long-term consequences in reducing and controlling alcohol and drug abuse.

At the present time, however, there has not been a major investment in prevention programs at federal, state, and local levels; the great bulk of funds have been invested in direct provision of treatment services to alcoholics and drug addicts. Nevada is no exception. Nevada's major prevention program is a series of study units on drug and alcohol problems developed at the University of Nevada for fifth- and sixth-graders; a similar series is being prepared for seventh- and eighth-graders. Some other programs are sponsored by the Department of Education and the PTA aimed at parents and other age groups. The FY 1975 expenditures for alcohol and

²² Kakalik, Brewer, et al., *Improving Services to Handicapped Children*.

²³ Bio-Dynamics, Inc., *Evaluation of the Rubella Immunization Program*, p. 28.

drug-abuse education by the Nevada Bureau of Alcohol and Drug Abuse were \$102,978.⁸⁴ It is unknown as yet how effective these programs have been, but pilot studies done by the University of Nevada show some positive attitude change. It remains to be seen whether the change will be enduring.

Aside from the school programs, there is very little prevention in Nevada; some TV spots have been prepared by various groups but there is no really major "public education" campaign in progress. The legislature has recently approved \$250,000 for continued education program development, and the Nevada Bureau of Alcohol and Drug Abuse has just received a \$50,000 two-year grant from the U.S. National Institute of Alcohol Abuse and Alcoholism to assist in staffing for prevention.⁸⁵ These new funds alone will do little to alter the present level of prevention activity. In total, we estimate that the annual alcohol and drug abuse prevention expenditures by all sources in Nevada are on the order of \$300,000 to \$400,000, with a full-time-equivalent staff of no more than five people.

Preventive measures have not been proven to be especially effective, with the possible exception of the strict supervision and regulation of the production of potentially addictive substances, which cannot be done effectively at the state or local level. With respect to drugs, Redlich and Freedman point out that past efforts to prevent addiction have achieved little, and that punitive approaches "discourage treatment, drive patients into the underworld, and remove them from medical purview. Most of all, it is highly doubtful that these approaches . . . are efficient."⁸⁶

Alcoholism is similarly resistant to prevention. Prohibition, a thirteen-year "social experiment" in prevention, was a failure. Some deterrent effect of unknown extent is probably achieved, however, through high liquor taxes, prohibition of sales to minors, and restrictions on locations and times of sale, all of which at least reduce drinking opportunities. Treatment and public education undoubtedly reduce the problem to some extent, but no conclusive work has been done to establish the relative merits and effectiveness of the few preventive options available.

It is an unfortunate fact that no one can say for sure what kinds of alcohol and drug abuse prevention programs are effective and should be promoted. The volitional element in such abuse, which makes prevention theoretically attractive, affords one of the few feeble rays of optimism in this otherwise murky picture. But until better information is available on the effectiveness of alcohol and drug abuse prevention programs, we cannot recommend any major expansion in the current prevention program in Nevada.

⁸⁴ Interview with Ruth Lewis, Bureau of Alcohol and Drug Abuse, Carson City, Nevada, May 1975.

⁸⁵ *Ibid.*

⁸⁶ *The Theory and Practice of Psychiatry.*

Chapter 6

IDENTIFICATION

INTRODUCTION

Identification, in the context of this study, is the recognition and correct assessment of a person's disabilities and abilities. Nationwide, it has long been one of the most serious gaps in recognizing and serving handicapped people. Both in the literature on the subject and in actual practice, there is no well-developed continuity of concern from earliest awareness of potential disability, to diagnosis, and on through post-identification service and follow-up after service. Nevada's experience with identification and subsequent services in the mental health and mental retardation service systems is no exception to this general point.

There are clear and meaningful connections and relationships between identification and several of the other services discussed in other chapters in this report, e.g., between direction, prevention, and actual treatment. Identification is distinguished from these other services, however, by virtue of the fact that it is mainly a recognition process and activity. To understand better what we mean when we talk about identification, we offer the following questions that need to be answered in establishing an effective identification program:

- By what mechanisms can a mental impairment be recognized and errors of identification minimized?
- What treatable pathological condition, if any, underlies the disability?
- Are secondary mental disabilities likely to be "caused" by the basic condition? For example, is the mental retardation or mental health problem of one family member likely to induce emotional disturbances elsewhere in the family or even precipitate a breakdown of the family unit?
- Can the condition be corrected, reduced, or prevented through timely intervention? At what age or point in time is such intervention most likely to be appropriate and hence identification needed?

At the total service system level, inadequate identification prevents one from accurately knowing the size and condition of the overall population in need of mental health, mental retardation, and alcohol and drug services. (Recall the discussion in Chap. 3 of prevalence rates for various disorders.) If a clear picture is lacking of the overall population's needs, including the names of people needing service, it is unlikely that sufficient service system capacity and a range of adequate services to meet these needs will be provided; that situation currently prevails in Nevada.

In the absence of organized information connections between specialists who provide mental health and mental retardation services (a problem treated in Chap. 4 and recurrently mentioned in this report), client follow-up and direction to the appropriate mix of needed services often are not done. Follow-up and adjustment of the supply and composition of services, taken from the perspective of the overall system, are consequently not done well either.

Aggregating all Nevada efforts to screen for potential mental handicaps prior

to full diagnosis, and to reach out to find potential clients for mental health and mental retardation service programs, we found that the total of all such efforts in FY 1974 cost perhaps \$200,000 to \$250,000. These cost figures do not include the cost of diagnosis following screening, nor do they include the cost of personnel who notice a possible mental disorder while they are primarily involved in providing some other service (e.g., education, medical, or social welfare services). The primary screening and outreach efforts we found were the early screening program for Medicaid-eligible children; a school screening program for all children in one rural county (the two counties with large populations do not screen all schoolchildren for mental handicaps); an outreach program of the Nevada Special Children's Clinics; and small, still rudimentary outreach programs at the Reno and Las Vegas Mental Health Centers.

There are several plausible reasons for the current weakness of identification as a service. In noting what appears to be the main reason in Nevada, our intent is not to excuse the current situation but to lay out the underlying rationales that must be understood in order to effect remedial courses. In interviews with service providers, we were repeatedly told that service capacity is insufficient to meet the current need and that the paucity of available services discourages referral initiatives; if the service system is already overburdened, it is logical to ask why one should bother hunting for still more clients. There are three answers to that question:

- Not all of those with the most need or the greatest ability to benefit from services are among those known to the service system.
- Were more of those in actual need identified, then the service system might eventually respond with a more adequate level of services.
- People in need can benefit from knowledge of the nature of their conditions, even if we assume that the public sector cannot serve them or chooses not to. With accurate and reliable information about the basic condition and services required, a person is somewhat better prepared to seek out private sources for care.

Finally, although the difficulties and possible ill effects of identifying and classifying people to be served have been well publicized, classification is useful in obtaining appropriate services for people in need, for planning and seeking support for programs, and for evaluation. The salient question is not whether people's needs should be categorized, but how that can best be done to minimize the sometimes negative effects of labels while retaining the positive effects resulting from categorization of needs.¹

The remainder of this chapter discusses the identification process, treats general problems with identification as a service, and discusses identification services that now exist in Nevada; the chapter ends with recommendations for action to improve the current situation.

¹ The classification of people with mental retardation or mental health problems is not to be taken casually. See T. Szasz, *Law, Liberty, and Psychiatry*, The Macmillan Company, New York, 1963; O. G. Simmons, *The Mental Patient Comes Home*, John Wiley and Sons, New York, 1963; N. Hobbs, *The Futures of Children: Categories, Labels, and Their Consequences*, Jossey-Bass Publishers, San Francisco, 1975; and a host of others who have been deeply concerned with the labeling problem and its various, sometimes unpleasant, side effects. An excellent empirical case detailing the problems of public opinion and mental health is presented in H. J. Halpert, *Public Opinions and Attitudes Toward Mental Health*, U.S. Public Health Service, Publication No. 1045, Washington, D.C., 1963.

IDENTIFICATION AS A PROCESS

Identification is a service, but it is also useful to characterize it as a process in the interests of understanding better what it is and why it is not well executed in Nevada and most other places. We have described the process in detail in our earlier work on handicapped children.² The constructive conceptualization of the process in Fig. 6.1 has been advanced by the Illinois Commission on Children; it is a good place to begin in figuring out where to go with identification.

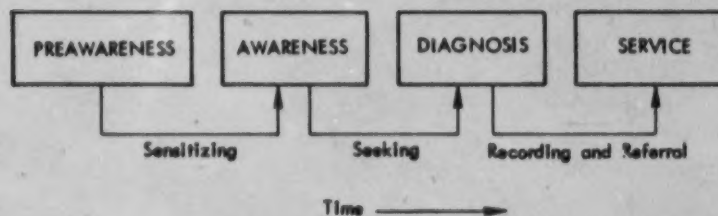


Fig. 6.1—Identification process (adapted from Illinois Commission on Children, Report of a Committee on Early Location and Care of Children with Handicapping Conditions, State of Illinois, Springfield, Illinois, January 1972, pp. 13-14)

At the preawareness stage no one has any suspicion of actual or potential disablement in the person concerned. That stage may be brief in the case of a severely retarded child, or last for months and even years in the case of a hard-to-diagnose emotional or behavioral disorder. One objective of identification is to reduce the time between preawareness and the delivery of needed services, and to minimize the chance that those services will never be delivered.

Sensitizing occurs when one or more people—parents, neighbors, friends, physicians, relatives, social workers, teachers, or the afflicted person—begin to sense that the person is somehow “different.” Sensitizing is enhanced if people are knowledgeable about the signals to look for; it would be particularly helpful if people who deal with children, such as teachers, were better informed about the symptoms of potential disorders.

Awareness is the partially confirmed realization that the person’s behavior or performance is not normal, with respect either to the person’s age or to certain more or less understood and widely accepted norms for behavior, as is the case for people with mental health disorders. Intelligence testing and other mass screening pro-

² G. D. Brewer, J. S. Kakalik, et al., *Improving Services to Handicapped Children*, The Rand Corporation, R-1420-HEW, May 1974.

grams for certain disorders concentrate on this phase of the identification process. The aim of such screening is commonly to identify those who are not behaving or performing up to normal levels expected for persons like themselves (for children of similar demographic characteristics and socioeconomic status, for example). Awareness is not diagnosis; it is a necessary precursor to competent and thorough diagnosis.

Seeking is a critical link between awareness and diagnosis. As awareness is not diagnosis, neither is it confirmation of a disorder; screening programs and other methods create awareness merely of potential disorders. A thorough individual examination by service professionals is still needed to confirm the presence of the disorder and to diagnose it. A child's falling below "normal" levels on a school intelligence test, for instance, may or may not indicate mental retardation. The test results may be erroneous or, more important, the child may not be *functioning* at a retarded level. Before sounding the alarm and disturbing both the parents and the child, it is terribly important to examine the child's functional abilities and determine why performance on the screening test was less than "normal." The child may simply have "had a bad day," for whatever reason; the testing situation may have been less than ideal; the tester may not have been well trained to administer the test; the test may have been inappropriate for children of the individual's age and socioeconomic or cultural characteristics; the child may have been taking medication (antihistamines have been implicated in slightly depressed performance on intelligence tests); or any of a host of other factors, both known and suspected, may have accounted for the child's below-normal performance.

Diagnosis is the thorough evaluation of the disability. Thoroughness in this sense comprises a full and forthright assessment of the disability, the services required, and the most likely and desirable futures for the individual, e.g., an individualized "plan" for services and treatment. The necessity for a full assessment of needs and services cannot be overstressed. Nonetheless, that assessment is denied to many of Nevada's citizens who need services because of disorders of mental health or mental retardation. The need for what we have termed the direction service is obvious during and following this phase of the identification process. Also, as obvious as it appears, once said, a thorough medical examination would assist in making a valid diagnosis; however, we find that in Nevada, and elsewhere, many people in the mental health and mental retardation service system have not had such an examination as part of the diagnostic process—or at least no indication of such an examination was carried on their active records (this was especially so for the mental health centers in both northern and southern Nevada).

Recording and referral, a "direction" aspect of the overall service process that follows identification (and is frequently missing), pertains to the follow-up carried out once diagnostic insights have been attained. If no one follows through with services, the most elegant diagnostic work-up in the world is wasted. Uneasy questions therefore arise. If the client needs medical attention, does he receive it? If periodic reevaluation of the disorder is called for, is it carried out? For example, if an alcohol or drug abuser is found to require detoxification and economic assistance, as well as psychological services, are the needed elements of a plan for services worked out and then pursued, or not? Failure to do so, or the neglect of even one element of the overall service plan for the client, may degrade efforts to fulfill other elements of treatment and service.

Service is the actual delivery of the needed services, in accordance with the client's diagnosed condition and needs. An obvious and critical but often neglected element of service is to keep track of the person who has an identified mental disorder until all necessary services have been completed. In Nevada, someone should verify that needed follow-up service has been provided to the client following, for example, discharge from the Nevada Mental Health Institute. Someone in the service system should check out the delivery of services to see that they are in fact being received and are achieving what was intended. A regional direction center would do this. We found follow-up services to be especially weak in Nevada, particularly in the mental health service (see Chaps. 8 and 10).

COMMON PROBLEMS WITH IDENTIFICATION

The problems that may be encountered in an identification program include failure to identify a large fraction of mentally handicapped people in need of service, misidentification, and inadequate follow-up. Each is discussed in turn below.

Failure to Identify

Failure in identification owes partly to society's not making the effort to find and serve all mentally handicapped people, and partly to the difficulty of identification. With respect to society's making the effort, Fig. 6.2 diagrams several strategic options. As shown, society can couple any level of identification effort with any level of service treatment and follow-up.²

Under option "a," existing levels of identification effort would be reduced or, at the extreme, eliminated altogether. The resulting reduction in service demand would be translated into a reduced bill for all types of services. That particular option is not really open to Nevada, however, where the level of identification efforts is already very low.

Reducing identification efforts while maintaining the current level of service expenditures (option "b") could have several outcomes: it could mean at least the same or better service to clients already in the system or fortunate enough to find their way in, or it could enable the concentration of services on those who are more severely impaired. Such a strategy would be plausible in the case of runaway inflation of medical costs, for example.

A decrease in identification resources with an increase in other system resources (option "c") might improve services for those fortunate enough to receive them, or enable an expanded variety of services. This strategy fosters the half-truth that "excellent" services are provided, at the expense of some number of the population in need who are unidentified and unserved.

Society could also maintain the status quo in identification and decrease, maintain, or increase other service provision. When the total capacity of the service system is reduced (option "d"), we arrive at a fair representation of the problem that

² The discussion in the following section draws from our earlier work on handicapped children, Brewer, Kakalik, et al., *op. cit.* We believe it necessary and useful to repeat here some of the points made in that study, although they are general in nature, they are related specifically to many pressing needs of the Nevada service system.

Level of Identification Resources	Level of Treatment and Follow-up Resources		
	Decreased	Maintained	Increased
Decreased	a	b	c
Maintained	d	e	f
Increased	g	h	i

Fig. 6.2—Strategic options in coupling levels of identification to levels of treatment and follow-up

currently besets some programs in Nevada, faced as they are with rapidly expanding and inflating service costs that result in a net real loss in total buying power of the dollar. The status quo is represented in option "e." Option "f" is to increase the system's other-service capacity while maintaining the present level of identification; the line of thought behind this option can be roughly expressed as, "We already have more clients than we can take care of adequately now, so let's improve things for them and not spread our resources any thinner."

Options "g" and "h" call for increased identification efforts, but with either the same or reduced levels of total service provision. In these cases, society would find as many handicapped people as possible, serve those assigned highest priority, and give the rest information on what services to seek privately.

Finally, society could increase both identification and total service provision (option "i"). This option would help realize the stated objectives of those responsible for the service system, and it is certainly the most beneficial option for mentally handicapped people in need.

This brief exercise summarizes a number of extremely difficult choices confronting responsible officials who face the problems of insufficient identification and other related services. The choices bristle with thorny moral, economic, and ultimately political considerations. On the one hand, it is in the clearest interest of mentally handicapped people to be made aware of their problems and to be diagnosed (the earlier the better, if remedial services are to have greatest effect). On the other hand, more and better identification may impose costs—of itself, and because there would be an undeniable obligation to do something for the additional people discovered. The tacit recognition of those costs may underlie many poor identification programs or explain the total absence of programs in some cases. Policymakers therefore must decide which course is the more prudent: minimal identification and "acceptable" services to those identified; or maximal identification and either visibly inadequate or more costly services.

In Nevada, total identification of those in need of mental health and mental retardation services clearly will mean significantly increased and expanded services, either publicly or privately financed, since the number of people in need is significantly larger than the mentally handicapped population currently served (see

Chap. 3 for a description of that population in Nevada). The question is a tough one, but it calls for honest resolution: If efforts are made to find those in need, will Nevada make an equal effort to serve those identified and provide the necessary resources? Or will those unserved now remain unidentified, making it easier, perhaps, to ignore their needs?

Even under a vigorous program of identification, however, some mentally handicapped people will go undetected as they do today, and for similar reasons. Some people are hard to identify because they do not routinely make contact with any part of the public or private service system (for example, babies, some preschool children, and physically healthy working adults). Some newborns with a known high risk of handicaps are not examined later to see if the handicaps materialized. Sparsely populated rural areas may require different types of identification programs from those in urban areas. And many mentally handicapped people may deliberately avoid being identified, or be kept from society's view and hence sometimes denied needed services because of fear, guilt-feelings, or ignorance on their own or their relatives' part. All of these reasons lessen the chances for complete identification, but an effective program can deal with several of them and partially reduce their unwanted and harmful effects.

Misidentification

Misidentification is represented by a classical problem of error types in the field of statistics. In this setting, Type I errors occur when those who are not mentally handicapped are screened and erroneously labeled handicapped. For example, a person may be identified as mentally retarded solely on the basis of an IQ test, when in fact no functional disability exists. Type II errors occur when screening fails to detect those who are in fact handicapped. A bright and clever adult who is severely emotionally disturbed, for example, may behave unobtrusively on the day of an examination and come up with enough "right" answers to escape detection. A combination of Type I and Type II errors also is possible. Screening may miss a child's deafness, for example, but mistakenly identify the child as mentally retarded. The results of error are usually distressing. Impaired people may be treated as "normal" and thus be denied the services they need, or, what is potentially worse, may be given the wrong services (and wrong impressions), as when a deaf child of normal intelligence is placed in a residential institution for mentally retarded people.

Excessive Type I, or "false positive," errors could indicate that screening criteria are too conservative in whom they permit to pass as "non-handicapped," or they could indicate the screening procedures are unreliable. Too many "false positives," if referred for specialized diagnostic procedures, may overload scarce and expensive diagnostic resources and gradually erode diagnosticians' trust in the seriousness or worthiness of the identification screening program. Nor should the injurious effects of misidentification on individuals and their families be discounted. It is shocking to be told that you or one of your family has a mental problem; it is tragic to labor under that impression when it is untrue. Some Type I errors are to be expected, however, when test subjects are very young and hence uncooperative, when the screening procedure or instrument is known to have a significant margin of error, when the disorder being searched out is not well understood and its present-

ing signs and symptoms are obscure or inconsistent, or when the testing personnel are inexperienced and make judgmental and procedural mistakes. Should any or all of these conditions hold in the actual test situation, several alternatives should be considered to reduce the impact of Type I error, since one "cries wolf" only so often until the cry is ignored:

- Personnel may be better trained, certified, supervised, and exposed to more screenings to gain experience.
- The screening instrument may be evaluated and improved.
- One may raise the age at which children are screened.
- Or, a second and third retesting may be performed on all positives initially screened, to confirm the first identification and to minimize false positives before they are referred to a diagnostician.

Excessive Type II errors, in which mentally impaired people pass undetected, indicate that the identification procedures are not discriminating enough. Too many "false negatives" can damage people by denying them needed services. Type II errors of identification can be expected when handicaps are slight, latent, subtle, or overshadowed by other more obvious problems, when the test instrument is faulty or too "coarse-grained" to discriminate the condition, when testing personnel are not properly trained and supervised, or when the actual causative etiology can be confused with some other handicap, as when a deaf child is incorrectly thought to be mentally retarded. One should think about the following remedial actions if excessive Type II errors are encountered in a given identification program:

- Train the personnel better, certify them, and alert them to the often subtle, subjective clues that may signal the presence of a handicap.
- Improve the test procedure or instrument, especially to increase the level of resolution to pick up more handicaps.
- Or, give repeated tests, both immediately and over time, with the same or similar, complementary procedures or instruments to give the disability every opportunity to demonstrate its presence. Such a procedure is particularly suitable for progressive or degenerative disabilities and for "high-risk" populations.

The special problems attendant to screening multiple handicapped and other hard-to-test people deserve special mention as a persistent source of misidentification. In the case of the mentally retarded child, for instance, there is no reason to believe that a "normal" intelligence screening test will reliably indicate either the presence or the absence of some other handicapping condition.⁴ Perhaps the mere presence of a mental disorder, whatever it may be, should entitle the person to a full medical diagnostic evaluation. Statistically, there is reason to believe that people with one handicap have a greater than average probability of being handicapped in other ways as well.

Inadequate Follow-Up

Significant breakdowns occur in the identification process between both the

⁴ The test instruments available are not infallible. See Lee J. Cronbach, "Five Decades of Controversy Over Mental Testing," *American Psychologist*, January 1975, pp. 1-14.

"Awareness" and "Diagnosis," and the "Diagnosis" and "Service" phases depicted in Fig. 6.1 above.

Breakdown in the first instance occurs when a person has been screened and is thought to be impaired, but nothing is done to secure competent diagnosis. Breakdown in the second instance is thought to be less frequent, but is still notable; it occurs when a full diagnostic work-up is carried out and the person is "identified," but nothing is done to provide the services indicated by the nature and extent of the disability and recommended by the diagnostician.

A screening program is nearly worthless without follow-up. The problem might be attacked simultaneously from several angles. General publicity about the nature and importance of detection of potential problems might help, for instance. Parents who are so informed, either through the media or by various types of service personnel, might give the general problems more attention, being alert to recognize gross signals of disorders in the individual and to search out competent care. The critical importance of the general medical practitioner has not received the attention warranted.

Formal procedures to help ensure follow-up could be instituted by every service program in which follow-up is appropriate. Creation of Regional Direction Centers would solve much of the follow-up problem (see Chap. 4).

Another and more difficult aspect of the breakdown phenomenon deserves more investigation: Why do individuals and their families either seek or not seek mental health and mental retardation services? What incentives operate in this matter? When we have more complete answers to these "simple" questions, we will begin to know how to provide not only better screening follow-up but better services generally. Follow-up in Nevada today, once a tentative finding of impairment or possible impairment has been made, is often left to the mentally handicapped person or to his or her close relatives. Some percentage of these people, for whatever reason, will not proceed to a competent diagnostician for clarification, confirmation, or rejection of the initial finding. Others will go, but only after some encouragement.

Follow-up is too important to be left to chance, and responsibility for it must be carefully and clearly defined early and maintained throughout the mentally impaired person's life. It is time-consuming, frustrating, and demanding work, but doing it correctly has been demonstrated to have considerable positive benefits in other health and mental health service areas.

IDENTIFICATION IN NEVADA

The general points made in foregoing sections highlight many unmet needs in Nevada's mental health and mental retardation service system. While we endeavor throughout this report to stress the positive and improving aspects of the service system, where they exist and warrant such treatment, remedial recommendations for improvement require full disclosure and confrontation of deficiencies. The following summary observations and evaluative comments are advanced in this constructive, rather than accusatory or destructive, spirit.

General Observations

In general terms, people who have a mental health problem, mental retarda-

tion, or an alcohol or drug abuse problem, become identified to the service system primarily through either of two mechanisms: (1) personnel in some segment of the service system (e.g., police, private physicians, or teachers) have "trouble" with an individual, or notice symptoms of a disorder, or (2) the individual or his or her family seeks assistance. Identification for certain disorders—mental retardation in school-age people, for example—could be done by a testing and screening program, but such screening programs do not exist in most of Nevada's counties, including the two large ones that account for about three-fourths of the state's population. Also, even if a mentally handicapped person is identified by one part of the service system, the mechanism of making referrals to all other appropriate service programs is often not used; therefore the person is often unidentified to and unserved by some or all of those other programs.

Since service needs exceed service capacity in most areas, each program could set priorities and use its limited resources accordingly. While it is true that most service programs in Nevada are already operating at full capacity, they are not serving all *high-priority* clients (or even as many of the high-priority clients as they might serve, since not all those high-priority clients have been individually *identified*).

Professional service personnel such as physicians, teachers, and social workers often fail to refer mentally handicapped people to other servers for various reasons: because they are unaware of the existence of some particular service program (an understandable eventuality in a system where so much new activity exists); because they in fact know that no service currently exists or that there is an excessive wait; or because they are very busy, and it takes time to keep informed about where to refer people (and even to refer them). Breakdown at this juncture also occurs sometimes because the identifying agent lacks confidence in the existing service or program to which the client might be referred, a factor we noted in several of our interviews with private physicians.

Follow-up, a critical feature of the identification process, often does not exist in Nevada's service programs except in instances when an individual service program or provider has made a special effort to provide it or when the families or the impaired individuals do their own follow-up. (The Special Children's Clinics are a notable exception to this criticism.)

One psychiatrist we interviewed alleges that the "token service coverage" provided by private non-psychiatric physicians to people with mental health problems, in the absence of sufficient service capacity in the mental health service system, has sometimes resulted in poor diagnosis and a breakdown of the identification and treatment process.⁵ This factor was similarly noted, especially with respect to timely intervention for children and adolescents, by two of the medical consultants employed in support of this research effort.⁶

An administrative tendency in Nevada that may impede full and accurate identification was noted by one physician in terms of the lessened use of individual diagnostic categories, especially for people with mental health problems.⁷ There are understandable reasons for not wanting to categorize and label a person unneces-

⁵ Interview with Dr. Donald Molde, private psychiatrist, Reno, Nevada, May 9, 1974.

⁶ Noted following interviews in Nevada by Rand consultants Dr. Robert Rubenstein, July 17, 1974, and Dr. Arnold Milstein, August 24, 1974.

⁷ Interview with Dr. William O'Gorman, Las Vegas, Nevada, October 31, 1974.

sarily, but the lack of meaningful diagnosis can impede timely and accurate treatment.

Identification in Education Programs

Schools could provide an essential component in screening for possible mental retardation and serious emotional disturbance in children, but they do not do so in either of the two largest counties with three-quarters of the Nevada population, and they do not do so in most rural counties. The identification programs in the Reno and Las Vegas areas, plus a commendable program in rural Churchill County, are summarized below.

Washoe County School District. In the Reno area, identification of mentally handicapped children in need of special educational services is accomplished by referral from parents, medical and public health personnel, teachers, and other school personnel. There is no screening program for all children to detect possible mental disorders. The school district has six psychologists (i.e., only about one for every 5000 schoolchildren in the county) to test referred children; and there is a waiting list for testing. About 25 to 35 percent of those referred are accepted for special education services.*

Clark County School District. The Las Vegas area also lacks a school screening program to identify children with mental health problems or mental retardation. Not all children in the school district receive an IQ or other screening test, and a child receives special education services only if the regular teacher notices a problem and refers the child to a school psychometrist for testing.*

Churchill County School District. While the two urban school districts do not screen all children for mental handicaps, the Churchill County School District (serving a rural county with a population of about 12,000 centered on Fallon) has a commendable identification program for screening all children at least once for special service needs.¹⁰ It is probably the best such program in any Nevada county. The district operates a preschool clinic in which about 99 percent of the children participate. This school-readiness clinic provides screening by both medical and school district personnel for hearing, vision, social development, emotional development, functional ability but not IQ, and any detailed evaluation the screening indicates as needed. So that children are not missed in the screening, every new admission to schools in the district must first go through a comprehensive screening similar to the preschool clinic screening, and any suspected disability is followed up with a more intensive evaluation. Coupled with the provision of services after identification, this comprehensive screening for mental and physical handicaps and incipient handicapping conditions, makes a good "prevention" program. The Churchill County School District provides identification services to Mineral, Nye, and Pershing Counties in the form of psychological testing services, while also using specialists from Washoe County (Reno) when needed for specialized medical testing of Churchill County children. It was noted that the screening clinic has been ap-

* Interview with Gerald Myers, Coordinator, Special Education Services, Washoe County School District, Reno, Nevada, August 19, 1974.

* Interviews with D. Seigle, Special Student Services, Clark County School District, Las Vegas, Nevada, March 5, 1974, and October 24-25, 1974.

¹⁰ Interview with W. Hammer, Churchill County School District, Fallon, Nevada, November 21, 1974.

proved for reimbursement from Medicaid under the early and periodic screening portion of that program, but the Churchill County School District does not request funding from Medicaid because "it is too much paperwork to ask for reimbursement."¹¹

Identification by Mental Retardation Service Programs

Like the mental health service programs to be described in the next subsection, most of the mental retardation service programs do not go out looking for potential clients to identify. For the most part, the Nevada Mental Health Institute, the two mental retardation centers, and the associated Interdisciplinary Committees screen potential clients who come or are referred to them (see Chap. 10 for a description of those programs). There are attempts by the several Associations for Retarded Citizens and Community Training Centers, and by the Mental Retardation Staff of the Nevada Division of Mental Hygiene and Mental Retardation, to make people in the community aware of the availability of services, but no specific screening programs have been established, even in the schools in most counties.

The Division of Health operates a program that is especially interesting because one of its prime objectives is to identify retarded preschoolers. Two Special Children's Clinics for mentally retarded and other developmentally disabled children aged 0 to 6 years primarily (although youth up to age 21 years are served) provide a variety of services. We have already discussed their direction services (in Chap. 4). The clinics place a heavy emphasis on identification and diagnosis, which we summarize here. Each also provides counseling (see Chap. 8) and operates a preschool (see Chap. 7).¹²

To carry out these tasks, each center has a full-time staff including a clinical psychologist, a psychiatric social worker, one (north) or two (south) child development specialists, one (south) or two (north) speech pathologists, and two secretaries. Complementing the full-time staff in each clinic is a pediatrician who works part-time diagnosing children, and a part time nutritionist and audiologist.

Two points must be noted in understanding services delivered by the clinics. Since their founding in 1957, the clinic staffs have expanded only minimally while Nevada's population has more than doubled; and the population in the catchment area and expenditures per person served differ considerably between the clinics. Basic funding for the clinics comes from the state legislature and federal Maternal and Child Health Services dollars, which are equally divided between the clinics. Other funds obtained are the result of the proposal-writing initiative of the two clinic administrators. In FY 1975 the northern and southern centers' budgets were about \$119,000 and \$87,000, respectively.¹³ Although the state divides the basic budget between the two centers equally, the southern center had about 60 percent more young children in its catchment area than did the northern center (based on 1970 Census data). However, over 95 percent of the southern center's population to

¹¹ Ibid.

¹² Information on the Special Children's Clinics was obtained through: interviews with Drs. J. Ashbaugh and J. Edwards, Directors of the Southern and Northern Nevada Clinics, respectively, 1974; a letter from J. Edwards to The Rand Corporation, February 26, 1976; and a letter from J. Owen, Director of The Southern Nevada Special Children's Clinic, to The Rand Corporation, February 27, 1976.

¹³ Data from M. Herman, Bureau Chief, Bureau of Maternal, Child, and School Health, Nevada Division of Health, June 1974.

be served was located in Clark County, whereas only 60 percent of children eligible for services from the Northern Nevada Clinic came from Washoe County. Thus, a major problem for the Reno clinic is the delivery of services over long distances to the 11 rural northern Nevada counties it serves.

During FY 1973, the Las Vegas clinic had 428 children on its active caseload, of whom 285 were under 5 years old. The Reno clinic had 297 children on its active caseload, of whom 128 were under 5 years old. Most of these clients had been diagnosed in previous years, however; new diagnoses per year number about 100 and 150 at the northern and southern centers, respectively.

If we divide the total clinic budget by the total number served, for FY 1973, the northern clinic spent approximately \$255 for each child served; the southern clinic, \$177.

For both clinics, referrals come from a myriad of sources—parents, private physicians, public health nurses, and the schools. A major difference between the two centers in 1974 was that the northern one had an outreach program to locate potential clients. With a developmental disabilities grant of \$35,000 for FY 1974, the Northern Nevada Special Children's Clinic began a training program for public health nurses in the identification of both high-risk mothers and developmentally disabled children. For FY 1975, another grant of \$24,000 has enabled the northern center to mobilize a traveling clinic, to provide services that year to only two rural counties. The traveling diagnostic team consists of a pediatrician, psychologist, speech pathologist, and social worker. This traveling diagnostic clinic has continued to function; between October 1974 and February 1976, a total of 15 clinics were held in rural areas. Beginning in late 1975, the Southern Nevada Special Children's Clinic also had a traveling diagnostic team.

An effective outreach program, particularly one involving distances of hundreds of miles, must provide a means for clients to reach its services. Otherwise, it becomes a contradiction in terms, a public service only for those who can afford to go to it or who live near it. Recognizing this situation, the northern clinic arranged through its 1974 developmental disabilities grant for some families to be reimbursed for traveling expenses to Reno for specialist diagnosis. The outreach programs in both clinics are a fine beginning, but continued development is hampered both by lack of necessary funds and by funding uncertainties. Strong outreach programs must be developed if these clinics are to fulfill their function effectively.

Both clinics have pediatricians who conduct half-day or full-day screening clinics once a week. Also on file, in addition to the medical work-ups, are reports of the clinic psychologist on test results and the social worker on family interviews, and the results of hearing, vision, and physical therapy examinations. The pediatrician at the Northern Nevada Clinic makes referrals to such specialists as neurologists and ophthalmologists when needed. The pediatrician at the Southern Nevada Special Children's Clinic typically conducts all physical examinations and neurological work-ups himself. For both clinics, inadequate funding and hence inadequate staffing have meant waiting lists for diagnosis, with sometimes up to several months delay.

The Special Children's Clinics are the logical units for providing genetic testing and counseling, and this is done at both clinics. (See Chap. 5 on prevention.)

Identification by Mental Health Service Programs

The various programs providing diagnosis, treatment, and follow-up for mental health disorders are described in detail in Chaps. 8 and 10; we summarize here the pretreatment identification services provided in some of the programs. In most programs for mental health treatment in Nevada, prediagnosis identification services are virtually nonexistent, e.g., outreach to locate potential clients who are not referred by others and who do not come at their own initiative.

Las Vegas Mental Health Center. There is little outreach to identify clients for the Las Vegas Mental Health Center—a breakdown of the identification process at its "Seeking" and "Awareness" phases.¹⁴ The situation is clearly a matter of priorities, as the Las Vegas Mental Health Center is in a period of rapid expansion to meet treatment service needs. In our view, this type of operation corresponds best to what we have called "option f" in Fig. 6.2; that is, to devote available resources to the clients at hand, who already number more than can be taken care of adequately.

The Las Vegas Mental Health Center does have a satellite center apart from the main facility. However, the indistinct delineation between outreach, intake, and treatment units of the satellite makes it difficult to determine what identification is taking place, if any. Outreach may be in operation, but from the records kept it is impossible to figure out what its impact might be.

Even if a client finds her or his own way to the Las Vegas Mental Health Center, there are still operational identification-related problems to contend with (see Chap. 8 for details on each of the following problems). The general deficient state of client recordkeeping found throughout Nevada's mental health service system also exists at the Las Vegas Mental Health Center. This can deprive key direct-service personnel of essential elements of information about a patient, even if the patient's problem was well diagnosed by some other service professional; it can also result in patients recycling through various phases of the identification process when they meet different service personnel, or if they return to the center at some time in the future. Another signal of a possible problem with the identification and intake process is the significant drop-out rate in the outpatient department; as of the summer of 1974, in excess of 35 percent of the clients dropped out between the time of the intake interview and the next appointment.¹⁵ In addition, we noted problems in 1974 of sometimes less than fully adequate diagnostics, and inadequate follow-up in the time period following inpatient care. We stress that these problems are not unique to this one mental health center, but occur in some others in Nevada.

Henderson Mental Health Center. In the summer of 1974 when we conducted interviews there, the very small Henderson Mental Health Center provided very minimal identification service. Outreach was negligible at the center, and no physician was in attendance during the period of our field inquiry.¹⁶ Owing to the lack of multidisciplinary professional support staff, most intake and diagnostic work was done by psychological clinicians and mental health technicians with relatively modest levels of training, considering the basic diagnostic skill requirements. In the

¹⁴ Interview with Dr. Larry Miller, Director of the Las Vegas Mental Health Center, Las Vegas, Nevada, July 17, 1974. Dr. Miller acknowledges that this is one of the known weaknesses of his operation.

¹⁵ Interviews at the Las Vegas Mental Health Center, August 8, 1974.

¹⁶ Interview with Mr. G. Everaul, Henderson Mental Health Center, August 6, 1974.

opinion of one of Rand's psychiatrist-consultants, staff at the time of our interviews did not appear to have sufficient multidisciplinary skills to make adequate judgments regarding diagnosis and treatment.¹⁷ Since that time, however, the center has hired a new clinic administrator and has acquired a larger multidisciplinary staff; by the time this report is published, the center may be providing fully adequate diagnostic services as part of the identification process.

Children's Behavioral Services. The Children's Behavioral Services program in Las Vegas for preteenage children had no significant prediagnosis identification program in 1974.¹⁸

Reno Mental Health Center. In 1974 the Reno Mental Health Center had a small program, staffed by two people and called the "public consultation and community education unit." Among other services, it provided some outreach and prediagnostic identification services. In mid-1974 staff members operated a branch office at Lake Tahoe a half-day a week, and said they regularly visited the police, parole agency, child detention center, Head Start program, and schools. They provided some consultation during those visits, and referred potential clients to the main center facility for diagnosis and possible treatment. Press releases also informed potential clients of the center's services. Since 1974, this unit has been phased out and its professional staff reassigned to strengthen other Reno MHC units. The adult and the adolescent/family units now carry the community education and consultation responsibilities.¹⁹ (See Chap. 8 for details.)

Nevada Mental Health Institute. For all intents and purposes, there is no prediagnosis identification service at the Nevada Mental Health Institute; service begins with diagnosis of patients who arrive there. (Chapter 10 contains a complete description.)

Rural Clinics. The Rural Clinics program places mental health personnel in several rural communities, but prediagnostic identification service is minimal. The people served are mostly self-referred "walk-ins from the street," to cite the program's director.²⁰ Furthermore, the overall lack of coordination in the entire mental health service system has resulted in haphazard notification (sometimes late and sometimes none at all) of Rural Clinics personnel when patients have been released from the Nevada Mental Health Institute and returned to their homes in rural areas.²¹ In identification terms, patients known to one part of the service system (the Institute) sometimes are not identified to Rural Clinics, which are to provide follow-up services. Cooperation among general practitioner physicians and Rural Clinics personnel, a necessity in a program with insufficient staff, also is sometimes minimal according to one Rural Clinics office head and others interviewed.²²

¹⁷ Dr. A. Milstein, following interviews at the Henderson Mental Health Center, August 6, 1974.

¹⁸ Interviews with J. Burnett, Children's Behavioral Services Administrator, and H. Platt, C. Hahn, D. Johnson, and B. Salisbury, CBS staff, Las Vegas, Nevada, March 6 and August 5, 1974.

¹⁹ Interview with Dr. T. Weyl, Reno Mental Health Center, July 3, 1974; letter from Mr. R. Keiffer, Reno Mental Health Center, to Dr. J. Kakalik, The Rand Corporation, February 27, 1976.

²⁰ Interview with Roger Glover, Rural Clinics program, Reno, Nevada, April 23, 1974.

²¹ Ibid.

²² Interview with Bruce Bilbrey, Director of the Rural Clinic in Elko, May 10, 1974. He states that many potential patients prefer to use their local physicians instead of the Rural Clinics, which operate, in his view, under a stigma of being welfare-oriented.

Identification by the Medicaid Program ²²

Although the Medicaid program emphasizes treatment (see Chap. 12 for a more complete description), since 1967 there have been federal provisions for mandatory early and periodic screening, diagnosis, and treatment of Medicaid-eligible children and youth under the age of 21. The purpose is to detect physical and mental problems and provide health care, treatment, and other measures to correct or ameliorate the problem conditions discovered.

In Nevada, screening is provided by the Economic Opportunity Board Clinic in Reno, by two screening centers in Las Vegas, and by public health nurses and private doctors. In addition, the Northern Nevada Special Children's Clinic provides diagnosis for developmental disabilities. Fees for screening run between \$15 and \$33. If a public provider screens, lab fees are included in the basic payment; if a private provider screens, lab fees are paid in addition to the basic screening fee. The program calls for screening to take place on a periodic basis, with a child screened on first becoming eligible for Medicaid and every three years thereafter.

Within the Division of Welfare, results of the Medicaid screening of children and youth are coded on a Health Screening Record, copies of which go to the screening agency, the district welfare office, and two to the child's parent (one for the referral physician). These collected data could be used to make sure all Medicaid-eligible children are screened, to establish a registry, and to keep track of the current status of patients to see they are receiving needed treatment, and to signal the time of periodic review. This, however, is not done. When we interviewed at the Division of Welfare, the raw data forms were simply piled in a desk file drawer, and according to the person whose desk it was, they were unused. The staff members we interviewed indicated that no one checks to see that all eligible children receive the mandatory screening, and no one checks to see how many mental problems are discovered or whether the children are referred and given treatment services. If the data were computerized, it would be easier to provide the follow-up needed. Currently, central office follow-up primarily concerns utilization of Medicaid money billed. It deals with matters such as whether a bill received was acceptable, and whether the client actually got the treatment the office was billed for. According to the central staff in Carson City, information (if available at all) on whether or not a child ever gets treatment for a condition discovered by the screening may consist only of a notation made by a district worker in the mother's file.

Outreach consists of the central office's notifying all welfare recipients at least once a year of their eligibility. The district office is responsible for notifying all new eligibles. Frequency and method depend upon the philosophy of the district office. In addition, some public screening clinic providers send out notices. On the other hand, we observed a surprising omission: the pamphlet describing Medicaid services published by the Nevada State Welfare Division does not mention, let alone describe, the early and periodic screening program. ²⁴

One problem may be that the screening payment schedule appears to be significantly lower than private rates. This deterrent, coupled with the paperwork and

²² Information obtained during interviews with Minor Kalso, who heads the Medicaid program within the Nevada Division of Welfare, and several of his program's staff members, Carson City, Nevada, August 16, 1974.

²⁴ Pamphlet Number 3-256 (Rev. May 1972).

sometimes delayed payments, may be limiting the number of private providers of this service, and may be significantly affecting the quality of the screening.

RECOMMENDATIONS

The two primary problems with identification in Nevada are: (1) many mentally handicapped people are not identified because of the lack of identification services, and (2) referral and follow-up for those who are identified are often lacking. The following recommendations are aimed at these two main problems.

Certain of the ideas developed in Chap. 5 on prevention are also relevant to identification. To reiterate, we recommend implementation of monitoring and enforcement mechanisms to help ensure that all newborn children are screened for phenylketonuria (PKU), and we recommend creation of a registry and follow-up of children born abnormal or at high risk of being mentally retarded or having some other handicap. Reporting to the registry by medical personnel could be mandatory. The registry and follow-up for high-risk children would be especially valuable in permitting early detection of retardation or other handicaps, so that preschool special education and training and other services (tertiary prevention) could begin at as early an age as is desirable.

There is no formal mechanism to screen and identify children, a key target population for any physical health, mental health, or mental retardation service system, after they leave the newborn nursery and until they enter elementary school. In this case we are speaking of a medical examination designed to detect a range of potentially debilitating mental and physical conditions so that services may be offered at as early an age as is desirable to help alleviate the effects of the mental or physical disorders.²⁵ Because comprehensive identification programs designed to reach all children simply do not exist in Nevada, we are particularly excited about the prospects of the recently mandated Child Health and Disability Prevention (CHDP) program in California. It is ambitious yet relatively simple in concept. (A description of the CHDP program is contained in Appendix C.) Its careful adaptation and adoption of some of its major tenets in Nevada would go a long way, in our view, to improving the early identification of handicapped children.²⁶ The program is not flawless; no program is, and we have reservations about the way California is implementing what otherwise appears to be an excellent program. (For example, the proposed Medicaid fee for a "developmental assessment" is a rather low \$3.30.) Rather, it is a long-overdue, first step toward improved identification that Nevada's

²⁵ The number of children who never see a physician in the period from 0 to 5 years of age may be as high as 25 to 30 percent of the total population of that age cohort. Interview with Dr. Frederick A. Frye, Department of Pediatrics, University of California Medical School, La Jolla, California, February 1972.

²⁶ The specific case of screening for mental retardation is carefully and thoroughly detailed in John Meier, *Screening and Assessment of Young Children at Developmental Risk*, The President's Committee on Mental Retardation, DHEW Publication (OS) 73-90, Washington, D.C., March 1973; this source contains the most extensive survey and review of screening and identification programs for the mentally retarded child that we have encountered. The general case is spelled out in K. Aileen Allen et al., "Early Warning: Observation as a Tool for Recognizing Potential Handicaps in Young Children," *Educational Horizons*, Winter 1971-1972, pp. 43-55, where Head Start, day care, and preschool nursery contacts are thought to be an underexploited and possibly important source of identification referrals. Each of these ancillary activities needs to be explicitly considered and evaluated by Nevada officials to determine the extent to which identification opportunities are being realized or not.

responsible officials should seriously consider emulating. The following are some of the most desirable features of the California program that we recommend for Nevada.

We recommend that parents of children beginning their first year of school, or entering a Nevada school for the first time from out of state, be required as a condition of admission of the child to present to the school either (1) the results of an approved health and developmental screening by an approved professional, or (2) a statement that the parents have decided not to have their child receive the screening services. This screening is valuable but not infallible for two primary reasons: parents may choose not to have their children screened for various reasons; and screening methods for the detection of mental disorders at the age of 4 or 5 years are not as valid and reliable as we would like them to be. Nonetheless, most of the more severely disordered children can be detected with existing screening methods. Care must be taken, however, not to label children for whom the results of the screening and later diagnosis are not clear-cut. Before implementing this recommendation, the screening methods to be used would have to be carefully considered. If these recommendations were adopted, the Medicaid Early and Periodic Screening, Diagnosis, and Treatment program would pay for the screening for Medicaid-eligible children. The results of the screening would be forwarded to the state (to a Regional Direction Center, ideally), where they could be used to follow up to see that the various appropriate mental health and mental retardation programs provide needed service at as early an age as is desirable, and to aid in planning future service programs. Implementation of privacy safeguards for people identified will be essential. Churchill County already has a related and commendable screening program provided by both medical and school district personnel for every child entering the school system.

The Federal Government has had difficulty getting some states to implement the required Medicaid Early and Periodic Screening, Diagnosis, and Treatment program.²⁷ Nevada has implemented this well-intentioned program but, as we indicated earlier in this chapter, the program as implemented has certain problems such as lack of checking to see that all Medicaid-eligible children are screened, and lack of adequate follow-up on the results of the screening. Consequently, to facilitate the provision of needed services, *we recommend that procedures be adopted (1) to help ensure that all Medicaid-eligible children and youth up to age 21 years receive early and periodic screening, unless such screening is formally refused, and (2) to help ensure that follow-up steps are taken to obtain diagnosis and treatment for those who need them.* The Regional Direction Centers (if created) would be useful in making referrals and coordinating needed services and follow-up. We note that implementation of this Medicaid screening recommendation would facilitate transfer of eligible clients from the Aid to Dependent Children program to the more desirable Supplemental Security Income program (see Chap. 14 of this report for details).

Regarding the two very small Special Children's Clinics that provide diagnostic

²⁷ See U.S. General Accounting Office, *Improvements Needed to Speed Implementation of Medicaid's Early and Periodic Screening, Diagnosis, and Treatment Program*, MWD-75-13, Report B-164031(3), Washington, D.C., January 9, 1975; John K. Iglehart, "Health Report/HEW Plans to Fine States for not Implementing Program," *National Journal Reports*, January 11, 1975, pp. 59-61; and Anne-Marie Folts, "Early and Periodic Screening, Diagnosis, and Treatment (EPSDT): The Development and Ambiguous Federal Policy," *Health Policy Project Working Paper Series*, Working Paper No. 2, Yale University School of Medicine, New Haven, Connecticut, June 1974.

services for mentally retarded youth, we recommend increased funding for these two centers, distributed between them more equitably on a per capita basis than it is now, with provision for stable funding of a traveling multidisciplinary team to perform diagnoses in rural areas for people of any age thought to be potentially mentally retarded on the basis of the results of screening programs. We note that some rural counties do not even have a school psychologist who could help with diagnoses.

The schools are an ideal setting for identification of mental handicaps in young people of school age, since nearly all children are assembled, observed, and compared on a routine basis. Since screening of schoolchildren is feasible and not excessively costly, and the human and social costs can be great if young handicapped people do not receive timely special services, all children should be entitled to at least one behavioral and psychological screening to detect possible mental retardation or serious emotional disturbance. Nevada lacks such a program. School psychologists in most counties do not screen all children; and since there are many unidentified mentally handicapped children in school, the mechanism of relying on teacher referrals has not been very effective. We recommend that a screening program be established in every county school district to identify all mentally retarded and seriously emotionally disturbed children who need special education and other services. A school district cannot adequately serve children with mental handicaps and refer them for other services if it does not know who they are. We earlier suggested that a medical and developmental screening program reach children before they first enter school. Here we are recommending that the schools conduct a different behavioral and psychological screening of all children when they reach a specified age (perhaps 7 or 8 or 9 years old) to identify any who were missed in the preschool medical and developmental screening or whose mental health or mental retardation problems developed or became identifiable in the years since the preschool screening.

It may also be desirable to train regular teachers and other service professionals (e.g., public health nurses and social workers) to recognize the symptoms of incipient emotional handicaps and mental retardation.²²

In the mental health area specifically, we have one additional recommendation. We recommend screening of high-risk populations to identify people who might be offered immediate mental health and other needed services to help alleviate existing mental health disorders before the persons become more seriously ill or dysfunctional. While a mechanism does not exist to readily reach everyone in high-risk populations, many can be reached through the mechanism of screening people who are in contact with public service systems for other reasons. For example, likely candidates for screening would be abused children and their abusers who come to the attention of health, welfare, and criminal justice personnel; juvenile and adult offenders; residents in the two Nevada Children's Homes; emotionally disturbed schoolchildren; children of a psychotic parent who is in contact with the mental health service system; and some callers to Crisis call and Suicide Prevention lines.

Once a person has been identified as potentially having a mental problem, the next steps are to obtain a professional diagnosis, develop a service plan, and implement services. Unfortunately, as we pointed out in Chap. 4 on direction and coordination services, the agency that identifies people may give them one service but

²² See E. M. Bower, *Early Identification of Emotionally Handicapped Children in School*, Charles C. Thomas, Springfield, Illinois, 1969 ed., and Allen et al., "Early Warning," pp. 43-45.

neglect to refer them for all other needed services, as when a seriously emotionally disturbed schoolchild gets special education but not psychological treatment. An agency is understandably most concerned with the services it provides, but this lack of global responsibility for seeing that all the needs of an individual are met can be detrimental. Consequently, *we reiterate our recommendation for the creation of Regional Direction Centers.* (See Chap. 4 for details). As soon as any service program or service provider in the state identifies a person as possibly mentally handicapped, those regional direction and coordination centers should be notified as soon as possible, to help ensure the provision of appropriate diagnosis, planning, referral, needed services, and follow-up. We cannot say strongly enough how important we believe it is to coordinate the present fragmented service system so that the full range of needs of each mentally handicapped person are considered and met. We urge that all previous recommendations made in Chap. 4 with respect to the direction service be implemented as soon as possible and that the information generated in the process be analyzed from the perspective of identification. Nevada needs to know who are the people in need; where they are located; how they enter the system and what entrance channels are underutilized; what are the main and subsidiary paths through the service system; what services have been effective; what groups of people located where seem to be under-identified (i.e., the number identified seems to be significantly less than the number thought to exist). Not only would this information begin to provide those responsible with some picture of the current compositional features of the population served, but it also would enable them to determine more accurately what facilities are needed and which service programs should be expanded.

A program requiring service professionals to report all mental handicapping conditions to the Regional Direction Centers (or, in their absence, to the Division of Mental Hygiene and Mental Retardation or the Bureau of Alcohol and Drug Abuse) should be carefully designed and implemented. We recognize the real possibility, in this case, of a clash between the right to privacy and the social desirability of service, but we believe that careful design of procedures that will ensure legal and moral safeguards is possible and desirable.

Chapter 7

SPECIAL EDUCATION AND TRAINING SERVICES

OVERVIEW OF CURRENT SERVICES

This chapter discusses special education and training services for mentally handicapped Nevadans, estimates the need for those services, makes projections to 1985, and presents recommendations for improvements. We are primarily concerned here with special education services for seriously emotionally disturbed children and youth to age 18 years, and special education and developmental training of mentally retarded people.¹ Chapter 11 discusses prevocational and vocational training services; Chap. 8 discusses psychological services for seriously emotionally disturbed children. While highly important, the special needs of "learning disabled" children are not within the central scope of this report, if they are not primarily mentally retarded or seriously emotionally disturbed. However, we present data on the special education programs serving "educationally handicapped" children, since children who are primarily emotionally disturbed, mentally retarded, or learning disabled are sometimes served together in Nevada under the label of "educationally handicapped," and since many children can be classed as either or both emotionally disturbed and learning disabled under the rather vague definitions of those terms (see the next section on county school district programs for details of those definitions as used in Nevada).

A handicapped youth's need for and right to education is generally accepted in the United States. While there is agreement that handicapped youth need special educational assistance, there is disagreement over what constitutes a severe enough impairment to handicap the child in obtaining an education, and what special assistance should be provided. We stress that there is a continuum of degree of need for special education; placing children in special classes for handicapped children or in special schools are only two of the many different ways of helping youth that are used by Nevada's special educators and discussed in this chapter. Many of these youth need special assistance but can still be educated primarily in regular classrooms. (It is beyond the scope of this study, however, to offer recommendations concerning the specific type of special education placement, curriculum, and teaching methods thought to be most appropriate for each specific type of child.)

We conservatively estimate that at least 2 percent of the school-age population in Nevada are mentally retarded and need some type of special education, and another 2 percent are seriously emotionally disturbed (see Chap. 3 for sources of these prevalence estimates). If so, at least 2650 emotionally disturbed children and another 2650 mentally retarded children aged 5 through 17 in Nevada needed some special educational assistance in FY 1974. If one assumes that mentally retarded children and youth need and can benefit more fully if education and training ser-

¹ See Chap. 3 for definitions and prevalence of handicapping conditions. The connotation of the term "seriously emotionally disturbed children" is that the emotional disorders of those children are severe enough that they have a substantial need for special education services.

vices are extended over a longer span of their lives, say from ages 3 through 17, then at least 3030 were in need in FY 1974.

The major special education and training programs serving mentally handicapped Nevadans, as shown in Fig. 7.1, are operated in two state departments, in county school districts, and in the private sector: the county school district special education (SE) programs operate under standards of the Nevada Department of Education and with partial state funding; the Community Training Centers (CTC) program consists of six very small private centers operating under guidelines and partial funding from the Nevada Division of Mental Hygiene and Mental Retardation; the Special Children's Clinics operated by the Nevada Division of Health have two small preschools and infant stimulation programs; and the Washoe County School District operates a special education and training program at the Nevada Mental Health Institute for retarded youth. In addition, a small federally funded program, P.L. 89-313, pays for special education personnel at some state facilities, and is described in Chap. 10.

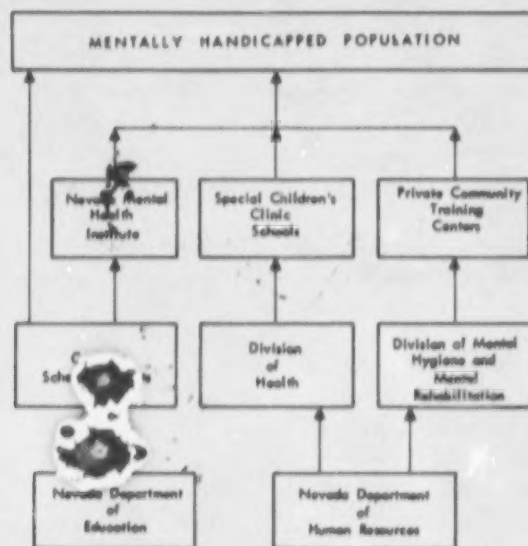


Fig. 7.1—Organization of major special education and training programs for mentally handicapped Nevadans

Table 7.1 gives an overview for each program of the number of mentally handicapped children served, teaching staff, and estimated expenditures in education and training programs in FY 1974 by type of mental handicap. Of the more than 3700 mentally or educationally impaired children receiving special education, only about 100 emotionally disturbed children are identified as being served in Clark, Churchill, and Washoe Counties combined. No seriously emotionally disturbed child is known to be receiving any appropriate special education services in any of the other

Table 7.1

SUMMARY OF SPECIAL EDUCATION AND TRAINING SERVICES
FOR MENTALLY HANDICAPPED NEVADANS, FY 1974

Number Served, Staff, and Expenditures	County School Districts	Community Training Centers	Special Children's Clinics	Nevada Mental Health Institute	All Programs Combined
Estimated number served					
Emotionally disturbed	100	0	0	0	100
Mentally retarded	1502	70	40	82	1644
Other mental (educationally handicapped)	1987	0	0	0	1987
Total	3589	70	40	32	3731
Estimated teaching staff (full-time equivalent)					
Emotionally disturbed	9	0	0	0	9
Mentally retarded	160	14	3	5	182
Other mental (educationally handicapped)	162	0	0	0	162
Total	331	14	3	5	353
Estimated expenditures					
Emotionally disturbed	\$ 225,000	0	0	0	\$ 225,000
Mentally retarded	3,750,000	\$168,000	\$53,000	\$100,000	4,071,000
Other mental (educationally handicapped)	5,050,000	0	0	0	5,050,000
Total	\$9,025,000	\$168,000	\$53,000	\$100,000	\$9,346,000

NOTE: See text of this chapter for sources of data.

counties in Nevada. Of the more than \$9 million expended in FY 1974 on special education of mentally handicapped Nevadans, only about \$225,000 was for identified seriously emotionally disturbed children. And of the 353 special education teachers serving mentally handicapped children and youth in Nevada, only 9 full-time-equivalent teachers worked with identified seriously emotionally disturbed children. The remainder worked with mentally retarded and educationally handicapped children and youth.

About 1644 mentally retarded children and youth received special education from 182 full-time-equivalent teachers with FY 1974 expenditures of approximately \$4 million. Mentally retarded individuals are the only ones receiving special education services from sources other than the school district, i.e., at the Community Training Centers, the Special Children's Clinics, and the Nevada Mental Health Institute. However, in terms of the number of people served, the county school districts provide the vast majority of all special education and training services for mentally retarded young people. The tertiary prevention of mental retardation (and mental health disorders) through the provision of special education services to help alleviate or eliminate the handicap is significant (see Chap. 5 for a discussion of prevention services). An economic benefit/cost analysis conducted by Conley, using national data, showed that "educational services provided to the mildly retarded can be justified on the basis of earnings alone. . . . It is, in fact, self-defeating not to provide these services, since this would sacrifice a large long-run gain for a small

short-run gain.² He was unable to support the same conclusion for moderately and more severely retarded youth, but he did not consider the major economic benefits of averting institutionalization of these people, nor did he consider the important quality-of-life benefits.

Over half of the possibly mentally impaired children served are not identified as either mentally retarded or as seriously emotionally disturbed. Nearly 2000 "educationally handicapped" children received special education from 162 full-time-equivalent teachers, with expenditures of over \$5 million in FY 1974. The characteristic most often possessed in common by educationally handicapped children is low academic achievement, and some of these children undoubtedly are mentally retarded or seriously emotionally disturbed, or both. Even so, the total number of children served with all types of mental and "educational" handicaps combined is far below the minimum estimate of the total number of seriously emotionally disturbed and mentally retarded children needing those services.

While the numbers of staff and children shown in Table 7.1 are known fairly accurately, the estimates of special education expenditures depend heavily on what proportion of certain expenditures are attributed to special education. The expenditure data in Table 7.1 are operating expenses for FY 1974, including special education teacher salaries and materials plus an allocation of a portion of the joint expenses that benefit both handicapped and nonhandicapped children (e.g., administrative and cafeteria costs). The expenditures shown generally do not include major capital expenditures for buildings. Specific expenditure data are presented later in this chapter for Clark, Churchill, and Washoe Counties, which contain more than three-fourths of Nevada's students; owing to the lack of better data, the special education expenditures for the remaining counties were assumed to be the same per special teacher as the average for the three counties on which we did have data. The higher expenditures per teacher for Clark County (Las Vegas area) in contrast to Washoe County (Reno area) are due primarily to allocation of more school expenditures to special education rather than being due to higher direct salaries³ or special education materials costs. Of the \$9.3 million shown in Table 7.1, about \$5 million came from state government for special education, less than \$1 million came from federal sources, and the remainder (about 40 percent of the total) were from regular county school district funds.

Table 7.2 shows the number of mentally handicapped people provided with special education and training services in the three major areas of the state. In terms of the total fraction of the school-age population provided special education and training services because of mental retardation, the rural counties (with an average of 1.50 retarded children served per 100 school enrollees) do slightly better than Washoe County (1.38 per 100), and Clark County is even lower (an average of 1.02 retarded children served per 100 school enrollees). Comparison of the three geographic areas based on the number of seriously emotionally disturbed children served in relation to need is not as important as the major point that special educational services for seriously emotionally disturbed children are extremely low in relation to need in all three areas. Special educational services specifically for

² R. Conley, *The Economics of Mental Retardation*, The Johns Hopkins University Press, Baltimore, Md., 1973.

³ The average salary for the 399 special education teachers in Nevada was \$11,240 in October 1973, ranging from a low of \$8,000 in Eureka County to a high of \$11,775 in Churchill County. Clark (Las Vegas area) and Washoe (Reno area) Counties averaged \$11,770 and \$10,863, respectively.

Table 7.2
SPECIAL EDUCATION AND TRAINING SERVICES FOR MENTALLY HANDICAPPED
NEVADANS BY GEOGRAPHIC AREA, FY 1974

Geographic Area	Estimated Number Served			
	County School Districts	Community Training Centers	Special Children's Clinics	All Programs Combined ^a
Clark County				
Emotionally disturbed	29	0	0	29
Mentally retarded	731	38	20	789
Other mental (educationally handicapped)	1133	0	0	1133
Total	1893	38	20	1951
Total per 100 school enrollees	2.43	0.05	0.03	2.51
Washoe County				
Emotionally disturbed	50	0	0	50
Mentally retarded	398	0	20	418
Other mental (educationally handicapped)	375	0	0	375
Total	823	0	20	843
Total per 100 school enrollees	2.72	0	0.07	2.79
All other counties combined				
Emotionally disturbed	21	0	0	21
Mentally retarded	373	32	0	405
Other mental (educationally handicapped)	479	0	0	479
Total	873	32	0	905
Total per 100 school enrollees	3.22	0.12	0	3.34

NOTE: See text of this chapter for sources of data.

^aExcept for 32 residents born throughout the state served at the Nevada Mental Health Institute, for whom we do not have the original county of residence.

seriously emotionally disturbed children are nonexistent in most Nevada counties, and the rest serve only a token number of children. Most of those children who do not receive needed special services attend school in regular classrooms, but what is probably a minority of them have been expelled or have "dropped out" so they are not in school at all.

Nationwide in 1970, an average of 1.6 mentally retarded children per 100 enrollment received special instruction or assistance; the comparable figure for emotionally disturbed pupils was 0.54 per 100.⁴ Nevada is below the national average in special education service to mentally handicapped children, and the national average leaves much to be desired.

Despite the state law requiring special education of all handicapped minors, we estimate that in relation to the minimum number of Nevadans needing special education and training services, only about 4 percent of seriously emotionally dis-

⁴ U.S. Office of Education, National Center for Educational Statistics, *Statistics on Education of the Handicapped in Local Public Schools, Spring 1970*, DHEW Publication No. (OE) 74-11113, pp. 77, 84, 111, 120.

turbed children are identified as such and served, and only about 54 percent of mentally retarded children and youth are served. Even if one assumes that every educationally handicapped child served is either mentally retarded or seriously emotionally disturbed (which is certainly not true), only about 63 percent of those in need are being served. The true number of mentally handicapped children in need is not accurately known, but we have used what we consider to be low estimates of need; and if we used, say, the 5 percent prevalence figure most commonly used by Nevada's Associations for Retarded Citizens, then estimates of the fraction in need who receive special education would be even lower (e.g., 36 percent of retarded children served).

The next several sections of this chapter provide a more detailed description of special education and training programs for mentally handicapped Nevadans. We suggest that the reader who is uninterested in descriptive details turn directly to the last section of this chapter, which discusses problems and recommendations for improvement.

COUNTY SCHOOL DISTRICT PROGRAMS

The county school districts provide the great majority of the special education services in Nevada, but do so under state regulations and guidelines and with the state paying more than half the expenses of special education. Accordingly, we first describe the special education regulations and guidelines set at the state level.

The 1973 session of the Nevada Legislature ordered that a school district "shall make such special provisions as may be necessary for the education of handicapped minors." A handicapped minor is defined in the statutes as "any person under the age of 18 years who deviates either educationally, academically, physically, socially or emotionally so markedly from normal growth and development patterns that he cannot progress effectively in a regular school program and therefore needs special instruction or special services."⁸ The age range to be served is 5 up to 18 years for educationally handicapped (including emotionally disturbed and learning disabled) children, and 3 up to 18 years for mentally retarded children.⁹ A handicapped minor is not required to take advantage of the special education program if the parent or guardian files a statement "showing that the minor is receiving adequate educational advantages." The Nevada Department of Education, by law, prescribes minimum standards for the special education of handicapped minors, and state funds can be withheld from a county failing to meet those standards. The state budget provides \$16,000 per year to the counties per special education unit (basically, a certificated special education professional), with a total of 506 units for all types of mentally and physically handicapped children being funded over the entire state in the FY 1976 school year (up from \$14,500 for each of 434 units in FY 1975).¹⁰

The following are highlights of the state-prescribed minimum standards. A special education program unit must be operated during at least nine months of a school year (with a school day of 330 minutes). A unit must have the full-time

⁸ Nevada Revised Statutes (NRS) 398.440-398.520, inclusive.

⁹ NRS 398.490, as amended, 1975.

¹⁰ Interview with L. Davis, Nevada Department of Education, Carson City, Nevada, July 9, 1975.

services of a certificated employee with an endorsement in the area of his or her major type of exceptional pupil teaching responsibility (see the certification standards below). Before admission to a program, a child must be examined individually with written permission from the parent or guardian to determine if he or she is a handicapped minor according to the state definition. Standards on the maximum number of enrollees for instruction at any one time must be met.⁹

The state defines two types of mental handicaps: "mentally handicapped" (basically, mentally retarded), and "educationally handicapped" (including emotionally disturbed and learning disabled children, as well as those in detention homes or correctional institutions).

Specifically, mentally handicapped (retarded) children are those

... who, as a result of ineffective intellectual functioning, are unable to profit educationally from a typical classroom situation.

Educable Mentally Handicapped. The performance on an individual psychoeducational evaluation shall fall within the I. Q. range of 50 to 75 in order for a student to be eligible for this program. (The psychologist may make a recommendation for placement of children falling outside the above parameters.)

Trainable Mentally Handicapped. The performance on an individual psychoeducational evaluation shall fall between the I. Q. range of 30 and 50 in order for the student to be eligible for this program.

Severely and Profoundly Handicapped. The performance on an individual psychoeducational evaluation shall fall below an I. Q. of 30 in order for a student to be eligible for this program.⁹

Educationally handicapped are those

... who, as a result of emotional disturbances and/or learning disabilities, require a differentiated educational program in order to make constructive use of their school experience. Children detained in detention homes or correctional institutions are educationally handicapped...¹⁰

Emotionally Disturbed. The performance on an individual psychoeducational evaluation shall determine that the emotionally disturbed are those students with persistent maladjustive behavior.

Learning Disabled. Children with learning disabilities exhibit a disorder in one or more of the basic psychological processes of central-motor, central-perceptual, central-cognitive, and/or spoken or written language. These disorders may be manifested in the areas of listening, thinking, talking, reading, writing, spelling, or arithmetic. The performance on an individual psychoeducational evaluation shall determine involvement in one or more of the following areas:

1. Marked discrepancies between intellectual achievement potential and achievement level
2. Perceptual motor impairment (auditory, visual, haptic)

⁹ Nevada Department of Education, *Standards and Instructions for Administration of Exceptional Pupil Education Programs*, November 15, 1973.

¹⁰ *Ibid.*

¹¹ All children in detention homes or correctional institutions are by definition classed as "educationally handicapped" so that they can receive special educational assistance.

3. General orientation defects (space, time, body image)
4. Disorders of speech and language
5. Developmental disparity in processes related to education (auditory, visual, haptic)

The maximum number of students to be instructed at any one time by a special education teacher ranges from 5 to 14 depending on the type of mental handicap and the age of the children; details are shown in Table 7.3.

An individual educational assessment is supposed to be made annually with goals and objectives written in measurable terms,¹¹ but we were unable to obtain any quantitative summary information from county or state personnel we interviewed on the effectiveness of the special education services.

As we indicated, to be eligible for state financial support for a special education unit, the unit's teacher must be certificated. The requirements for certification for special teaching of mentally handicapped (mentally retarded) children are basically either:

- A bachelor's degree and completion of an approved program of preparation for teaching the mentally handicapped

or

- A bachelor's degree, valid teaching certificate and completion of the following:

Completion of a program for teaching the mentally handicapped consisting of no fewer than 24 semester hours course work distributed to include preparation in each of the following areas, or their equivalent:

- A minimum of six semester credits in student teaching with the mentally handicapped
- Survey of the exceptional child and/or introduction to special education
- Curriculum development and/or methods of teaching the mentally handicapped
- Diagnosis and remediation of learning disorders
- Counseling and guidance for exceptional children
- Career education¹²

A certificate endorsed for teaching educationally handicapped children is required for special teaching of emotionally disturbed and learning disabled children. The requirements for the certificate for educational handicaps are basically either:

A bachelor's degree and completion of an approved program of preparation for teaching the educationally handicapped, emotionally disturbed or learning disabled

or

- A bachelor's degree and a valid certificate endorsed for teaching in the elementary or secondary grades, and completion of the following:

A program for teaching the educationally handicapped, consisting of no fewer than 24 semester hours course work distributed to include preparation in each of the following areas or their equivalent:

¹¹ Nevada Department of Education, *Standards and Instructions*.

¹² *Idem*, Nevada Teacher Certification Requirements, Carson City, Nevada, September 1, 1974.

Table 7.3

**MAXIMUM NUMBER OF SPECIAL EDUCATION STUDENTS TO BE
INSTRUCTED AT ANY ONE TIME BY A TEACHER**

Age Range	Type of Handicap				
	Educable Mentally Retarded	Trainable Mentally Retarded	Severely and Profoundly Retarded	Emotionally Disturbed	Learning Disabled
Preschool	8	6	5	6	8
Primary	10	8	5	6	10
Elementary	12	10	6	10	12
Junior high	14	10	8	10	14
Senior high	14	12	8	10	14

NOTE: Except for the severely and profoundly retarded, the numbers shown can be increased by no more than four if a teacher's aide is present. Nevada Department of Education, *Standards and Instructions for Administration of Exceptional Pupil Education Programs*, Carson City, Nevada, November 16, 1973.

- Introduction to the psychology and education of the exceptional child
- The learning disabled child
- The emotionally disturbed child
- Counseling and guidance for exceptional children
- Measurement and evaluative techniques
- Curriculum development and methods for teaching learning disabled and/or emotionally disturbed children
- A minimum of six semester hours credit in student teaching of the educationally handicapped¹³

Endorsement as a school psychologist requires:

- A master's or doctor's degree and completion of an approved program of preparation consisting of at least 50 semester hours credit, 36 of which are at the graduate level, distributed to include course work in each of the following areas and sub-areas:
 - Characteristics of school populations (normal and exceptional) ...
 - Characteristics of school systems ...
 - Psychological assessment ...
 - Intervention techniques ...
 - Experimental design ...
 - Internship
- 480 clock hours in supervised field work in school psychology of which at least 240 hours will have been in elementary and secondary school settings¹⁴

The University of Nevada at Reno has three professors of special education and annually graduates 40 to 45 people with bachelor's degrees and about 20 people with master's degrees in special education. Teachers are prepared for certification in the

¹³ Ibid.

¹⁴ Ibid.

areas of educable mental retardation, trainable mental retardation, and educational handicaps. About 90 percent are placed in jobs within the state or on the nearby eastern slope of California's Sierra Nevada. Many of the master's degree graduates are teachers who come for retraining in special education, but of the dozen or so rural teachers that come into the master's program each year from rural areas, only about half return there.¹⁵

The special education program at the University of Nevada in Las Vegas, with seven professors, is about twice the size of the Reno program. The Las Vegas program prepares bachelor's degree level graduates for certification in the areas of educable and trainable mental retardation, severe and profound retardation, and educational handicaps (combining learning disabled and emotionally disturbed).¹⁶ The university does not offer a separate program for training teachers in special education of emotionally disturbed children and youth.

In the remaining subsections on the county school districts' programs, we briefly describe special education programs in the three largest county school districts with over three-fourths of Nevada's school-age population (Carson City, Clark, and Washoe Counties). We also briefly describe the special education programs in two rural counties (Churchill and Douglas). The numbers of special education students and teachers, which we summarized earlier, are presented in detail for each county by type of mental handicap in Table 7.4.

Carson City School District¹⁷

The Carson City School District has the third largest number of certificated special education professionals in Nevada—2 speech therapists, 2 teachers for trainable or more severely mentally retarded children, and 11 teachers for "learning disability" units who were said actually to be serving many mentally retarded children. In Carson City, the one school psychologist tests children (about 300 were tested in the 1973-74 school year), writes an individual plan for each child, works with the teacher in implementing the plan, and provides direction and referral to other service providers. A Reno physician helps in the evaluation of some children.

Children placed in special education are followed up by the school psychologist in six weeks, three months, and nine months. In Carson City there is no psychological counseling by the school psychologist, although some emotionally disturbed children are referred to the Rural Clinics mental health personnel.

Data reported by the Nevada Department of Education indicated that 41 mentally retarded and 77 educationally handicapped children were being served in special education in Carson City at the start of the FY 1974 school year.¹⁸ If the teachers are assigned in about the same ratio as types of special education students, there were about 5 full-time-equivalent teachers serving retarded children and 8 serving educationally handicapped children.

¹⁵ Interviews with Professors J. Campbell and T. Tower, University of Nevada, Reno, November 21, 1974.

¹⁶ Interview with Prof. W. Wagonseller, University of Nevada, Las Vegas, October 24, 1974.

¹⁷ Interview with Muriel Keohn, Psychologist, Carson City School District, May 9, 1974.

¹⁸ Nevada Department of Education, *Research Bulletin*, Vol. 16, No. 1, January 1974.

Table 7.4
SPECIAL EDUCATION IN NEVADA COUNTIES, 1973-74 SCHOOL YEAR

County School Districts	Total School Enrollment, First Month of School	Approximate Special Education Enrollment			Approximate Full-time Equivalent Special Education Teachers		
		Total Mental	Mental Retar- dation	Emotional Disturbance	Total Mental	Mental Retar- dation	Emotional Disturbance
Carson City	5,381	118	41	0	77	13	0
Churchill	2,990	200	80	20	100	12	2
Clark	77,862	1,893	731	29	1,133	175	3
Douglas	2,438	43	43	0	0	4	0
Elko	4,062	71	53	0	18	10	0
Esmeralda	97	18	4	0	14	2	0
Eureka	203	11	0	0	11	1	0
Humboldt	1,717	43	22	1	20	4	0
Lander	765	35	35	0	0	3	0
Lincoln	736	25	7	0	18	3.5	0
Lyon	2,617	132	27	0	105	9	0
Mineral	1,762	37	10	0	27	5	0
Nye	1,270	53	0	0	53	5	0
Perkins	647	27	0	0	27	2	0
Storey	107	0	0	0	0	0	0
Washoe (except NMHI)	30,374	823	308	50	375	76	4
White Pine	2,388	60	51	0	9	7	0
Total, except Clark and Washoe	27,170	873	373	21	479	80	2
Total, all counties	135,406	3,589	1,502	100	1,987	331	9

SOURCES: For Elko, Esmeralda, Lincoln, Lyon, Mineral, Nye, and Storey: Nevada Department of Education, *Research Bulletin*, Vol. 16, No. 1, January 1974, and *idem*, "Special Education Program Units-1973-74," unpublished data, 1974.

For Eureka, Humboldt, Lander, Perkins, and White Pine: the same sources plus interview with W. Green, Special Education consultant for rural counties, University of Nevada, Reno, November 21, 1974.

For Carson City, Churchill, Clark, Douglas, and Washoe: see text discussions of individual county programs for variation from the foregoing data sources.

Churchill County School District¹⁰

The Churchill County School District is discussed in more detail than other rural Nevada districts because of its reputation as having one of the better rural county special education programs. Churchill County has about 12,000 people. Over 98 percent of its school children live within 15 miles of the town of Fallon, where all special education services are provided; no handicapped children are sent to other counties for service.

Churchill County has six schools, all in Fallon. Sixty-eight percent of the children in the school district are bussed. The longest commute by school bus is 70 miles (taking 1 hour and 20 minutes) each way. Three children make the 70-mile commute, and the district is considering using a private plane to fly the children in each day. Since so many of the children are within a 15-mile radius of Fallon, the commuting problem is not as difficult as it might seem to be at first.

The six Churchill County schools include one for kindergarteners only, one that is ungraded and serves only children in the first and second years of their schooling, one that is ungraded and serves only children in the third and fourth years of their schooling, one that serves fourth, fifth, and sixth graders, one graded junior high school, and one graded senior high school, which was said to be very vocational in its curriculum.

In 1974 there were about 3000 children in school in Churchill County, of whom 10 to 11 percent were said to need some form of compensatory education. W. Hammer, who is in charge of special education in Churchill County, avoids the term "special education," however, because he believes it usually entails labeling. He prefers to provide compensation for specific deficits in the individual child's abilities, rather than label groups of children under a common classification and provide the same special education services across whole groups.

The county is reimbursed for nine special education units by the state, but operates a total of 13 units. Thus, Churchill County goes well beyond what the state provides in terms of units, contrary to the practice in the much larger Clark and Washoe Counties. However, Hammer indicated that they are still not serving all the known handicapped children, and if they served all the learning disabled children who have been identified, they would need 12 or 13 more special education units.

The current 13 units are located in regular schools. There are four self-contained classes serving a total of 62 children, most of them educable mentally retarded but a few with different types of handicaps. The children are divided into primary, elementary, junior high, and senior high age groups. The district also runs two self-contained classes serving 18 emotionally disturbed children of elementary school age, and four self-contained classrooms for 75 to 80 learning disabled children. Two units provide a "flow-through resource type class" where some 60 to 70 children are seen for one-half hour each in a one-teacher-to-three-student setting. One unit of speech therapy is also provided in the district. All children work on a "diagnostic prescriptive program" prepared for each individual child by the school psychologist and two reading specialists. If a child has a severe emotional disturbance that cannot be handled through a day-care program in the schools, a psychiatrist from Reno provides consultant services in the short run; in the long run, W.

¹⁰ Interview with W. Hammer, Churchill County School District, Fallon, Nevada, November 21, 1974.

Hammer indicated that the child must leave the county to receive adequate service. He also indicated his feeling that the mental health personnel of the Rural Clinics program in Fallon in late 1974 could not deal effectively with severe emotional disturbance. In total, the district in late 1974 was providing special educational services to about 80 to 90 retarded children, about 20 emotionally disturbed children, and about 100 children with learning disorders.

The special education and related staff consists of the director and one secretary, the 13 professionals associated with the 13 special education units (11 of the 13 were primarily serving children with mental problems), and 18 aides at the elementary grade level providing one-to-one education based on prescriptions written by professionals. In addition, the district employs two psychologists and five school nurses, and has one counselor for each school. Churchill County recruits in several states, apparently has little difficulty obtaining qualified teachers, and typically pays about \$12,000 per school year for special education teachers. In-service training workshops for the special education teachers are conducted by the county special education director and by other staff members.

The 1974-75 budget for education of all children in Churchill County was about \$4 million. In special education, the direct personnel and material cost (exclusive of facility and overhead) came to \$245,000, of which only about \$130,000 came from the state, and about \$60,000 was a federal grant (under Title I of the Elementary and Secondary Education Act) to pay for the 18 special aide personnel. In a breakdown of 1970-71 special education costs,²⁰ which Hammer said was as accurate as any he could prepare in 1974, the direct costs were shown to be about 70 percent of total operating costs. Thus the total 1974-75 special education operation costs in Churchill County would be about \$350,000, of which slightly under \$300,000 was for children with some type of mental impairment (if costs are assumed to be in proportion to the number of children of each type served).

Churchill County has a commendable program for screening all children, at the time they begin school or transfer into the school system, for the presence of functional mental retardation and impaired emotional development (see Chap. 6 on the identification service for details).

Clark County School District²¹

The Clark County School District is the largest in Nevada. It serves more than half of Nevada's school-age population: approximately 76,500 students in the 1973-74 school year at 96 schools. The great majority of the people in the county live in the Las Vegas area, where all special education services are provided, with the following exceptions. Henderson has three special education units (teachers) and Boulder City has one. All mentally handicapped children in those two cities spend most of their time in the "mainstream" in class with nonhandicapped students, with the exception of a few trainable or more severely retarded or multiply handicapped students who are bussed to two special schools in nearby Las Vegas. In the rural

²⁰ "Churchill County School District Special Education Costs, 1970-71," unpublished, obtained from W. Hammer.

²¹ Information in this section, unless otherwise noted, is based on interviews with Dorothy M. Seigle, Special Student Services, Clark County School District, Las Vegas, Nevada, March 5, 1974 and October 24-26, 1974.

areas of Clark County, special education is provided in Overton, Indian Springs, and Virgin Valley; each has one special education teacher who serves both educationally handicapped and educable mentally retarded children of several ages. Private special education is virtually nonexistent in Clark County. There is one special education teacher in a parochial school.

In the Las Vegas area, the program specifically for emotionally disturbed children consists of one teacher serving adolescents in temporary residence at the Las Vegas Mental Health Center, and two teachers serving elementary school-age children in what is called the MOD Center, run jointly by the Clark County School District and the Children's Behavioral Services branch of the Nevada Division of Mental Hygiene and Mental Retardation in 1974. (See Chap. 8 of this report on psychological services for descriptions of these two programs, which are more for treatment of emotional disturbance and behavior problems than for special education). Other emotionally disturbed children are served within the school district in the program for educationally handicapped children, where the common characteristic of all students is academic performance at least 50 percent below the average for that age of child. Other than initial testing and teacher-provided therapy, psychological services are virtually nonexistent.

The difference between programs for the educable mentally retarded (EMR) and the educationally handicapped children is that the EMR children are more often in self-contained classes, and the educationally handicapped children are more often in remedial education programs designed to get them back into the mainstream. In practice, a principal can place a child in special education when the only problem is low reading achievement. An educationally handicapped child must meet normal graduation requirements, whereas a mentally retarded youth does not. Educable mentally retarded children who have severe behavioral problems are not served by the present school system in Clark County, although the MOD Center program may attempt to get some of them back into special education in the future.

Most handicapped children in special education in Clark County do some schoolwork with nonhandicapped children, e.g., physical education. Those that spend much of their time with nonhandicapped children are in what has become known nationally as the "mainstream." In Clark County there are two basic types of special education called mainstreaming: in one the child is primarily assigned to a special class but is sent to regular classes for physical education and one or two other subjects; in the other the child is primarily assigned to a regular class but the child's education is supplemented by a special education resource teacher. The district receives no special education funding from the state for the regular mainstream class teacher, but does receive state funding for the resource teacher. Mainstreaming is being tried in Clark County, with some apprehension over whether the reduction of special classes will result in more children being placed in special schools, and over whether principals will use special education resource teachers as remedial teachers for children who are not substantially handicapped.

The Medical Consultant Program operated by the Clark County School District in cooperation with the County Health Department was developed mainly to diagnose and treat students with symptoms of hyperkinesia, although children with serious learning problems for whom there is no other medical resource will also be seen. In the 1973-74 school year, 87 children were referred to this program, of whom 80 were placed on medication and 7 were referred elsewhere for medical help.

The county does not supervise the special education staff at the local school. The local principal is in control and there is no regular consultant help to the local special education teacher, although coordination and consultative assistance from the district are available. Consequently, the local teacher has much independence. Funds were said to be needed for consultant help to the teachers, but they are not provided under the present state formula. Thus the local teacher has little help in curriculum and other types of education program development unless he or she is part of a federal project. For example, the district is using the federal dollars to employ two staff members to teach the teachers in the mainstream program in 18 schools.

In-service training of special education teachers is provided only if the special education teacher asks for it. The teacher then might be allowed to go to a workshop, for example, or attend a course at the university.

A total of 731 mentally handicapped students were enrolled in special education in the Clark County School District in the first month of the 1974-75 school year: 215 educable mentally retarded children at the elementary school-age level; 275 educable mentally retarded youth at the secondary school-age level; 142 trainable and more severely retarded children at the special Helen J. Stewart school; and 99 multiply handicapped children (mentally retarded plus some other handicap) at the special Variety School. Some special educational services were provided to 9 adolescents with mental health problems who were in residence at the Las Vegas Mental Health Center; and to about 20 emotionally disturbed elementary school-age children in the MOD Center program operated jointly with the Children's Behavioral Service branch of the Nevada Division of Mental Hygiene and Mental Retardation. Special educational services also were provided to 1133 "educationally handicapped" children. These numbers of enrollees are approximately the same as those at the end of the FY 1974 school year.

In 1974, the school district was serving no children less than five years old, with the exception of three severely and profoundly retarded four-year-olds at the special Helen J. Stewart School. The State Division of Health's Southern Nevada Special Children's Clinic, however, was serving about 20 three- and four-year-old mentally retarded children of Clark County in a nursery school program.

In Clark County there is no screening program to identify children with mental health or mental retardation handicaps. Not all children receive an IQ test, and a child receives special education services only if the regular teacher notices a problem and refers the child for special education.

In the spring of 1974 Clark County had what was termed a "huge waiting list" for special education (66 educationally handicapped and 14 educable mentally retarded children). All but one of the children on the waiting list were in regular school classes. By the fall of 1974 the children on the spring waiting list had been placed into special education and the fall waiting list was very small (exact number unknown). However, there were said to be many referred children who had not been tested, because of a shortage of psychologists. However, every identified trainable mentally retarded person of school age in Clark County was said to be receiving special education.

In the 1973-74 school year, Clark County had about 233 special education units (certified professional special education personnel units), of whom 59 served educable mentally retarded children, 14 served trainable or more severely retarded chil-

dren, 6 were special education vocational counselors primarily for mentally retarded youth, 9 served multiply handicapped retarded children, and 87 served educationally handicapped children (including one at the Las Vegas Mental Health Center and two at the MOD Center for emotionally disturbed children). In addition, there were 18.5 full-time-equivalent psychologists, 11.5 full-time-equivalent social workers, and 16.5 full-time-equivalent school nurses serving all types of nonhandicapped and handicapped students.

Psychologists are paid by county school districts and are not reimbursed by the state as special education units. Psychologists mostly do psychometric testing and "don't do individual case work or therapy with individual students." Psychologists sometimes try to counsel teachers on how to handle the children (but are able to spend only a small percentage of their time on this) and thus seek leverage by training other service personnel. The Clark County rule is that one social worker or psychologist is provided for about every 3000 students.²³

The salary range for teachers begins at about \$8000 per year and extends to above \$16,000; special education teachers receive an additional \$200 per year. The district does not actively recruit since it has sufficient numbers of high-quality applicants for special education teaching jobs.

The annual operating expenditures for special education in Clark County are not precisely known, and the use of the \$14,500 per unit provided by the state in FY 1974 is not accounted for separately in the expenditure records.²⁴ However, using the following two alternative methods of estimating the total annual special education operating expenditures, we estimate the total for FY 1974 for mentally handicapped students was approximately \$5.2 million. The first method of estimating special education expenditures was to use estimates of \$3500 per year per pupil for the expenditures on children in the two special schools in the district,²⁵ \$2683 per year per educationally handicapped pupil,²⁶ and \$2500 per year per educable mentally retarded student.²⁷ This results in an estimate of \$5,187,000 for FY 1974 special education expenditures for mentally handicapped students in Clark County. The second method we used to estimate those expenditures was based on an estimate by the Clark County special education administrative staff that in FY 1974 the county provided at least half of the total special education expenditures. Given the state funding of \$14,500 per unit and the number of units, and assuming that county funding was at least half the total, leads to an estimate of at least \$5,075,000 for FY 1974 special education expenditures for mentally handicapped students in Clark County. This is very close to the estimate obtained by the first method, which is probably the more accurate of the two. By type of mental handicap, using the first method of estimation, the FY 1974 expenditures for special education in Clark

²³ Interview with Clair McKee, Chief of Psychology and Social Work Services, Clark County School District, Las Vegas, Nevada, October 24, 1974.

²⁴ The unit figure was raised to \$16,000 by the 1975 session of the Nevada Legislature.

²⁵ Per pupil expenditure data at the Helen J. Stewart and Variety Schools, obtained from the principals of those two schools, October 24-25, 1974.

²⁶ Based on the most recent available data on special education expenditures per educationally handicapped pupil in Clark County ("Clark County School District Special Education [Expenditures]—1971-72," mimeograph, undated), with an adjustment upward of 5 percent per year for inflation. This 5 percent inflation is thought to be a low estimate of the unknown inflation rate in the cost of special education from FY 1972 to FY 1974.

²⁷ Based on adjusted FY 1972 special education expenditures per educable mentally retarded student in Clark County. See footnote 25 for source of data and adjustment factor.

County were: \$2.1 million for mentally retarded students, and \$3.1 million for educationally handicapped (including emotionally disturbed) students.

Helen J. Stewart School.²⁷ The Helen J. Stewart School, a separate day school, has a high-quality facility, staff, and program for special education of trainable and more severely retarded children in Clark County. It is the best special education program for such children in Nevada, and in our view compares favorably with the better programs for trainable and more severely retarded children nationally. Approximately 142 children aged 4 to 18 are served, of whom half are over the age of 12. Sixteen are severely or profoundly retarded. Dr. Robert Foster, the principal, indicated he knew of very few trainable or more severely mentally retarded children of school age in Clark County who are not being served. The modern facility was designed specifically for service to those types of youth after visits to several exemplary facilities nationwide. The school provides physical therapy and physical education, vocational training, and training in activities of daily living, and possesses a one-acre farm, greenhouse, and several classroom-type areas. The professional staff includes 15 teachers, 2 social workers, a clinical psychologist (2 days a week), a speech therapist, a vocational specialist, and a physical therapist. There are several teachers' aides, and between 100 and 200 volunteers provide some assistance each week. (These volunteers also raised about \$40,000 in funding during the 1973-74 school year.)

The program for severely and profoundly retarded children at the Helen J. Stewart School is behavior modification oriented, with one teacher and one teacher's aide for every four such children. Both parents and teachers of these children sign a "contract" specifying what each is to do, and parents spend one evening each month at the school for consultation and for training in how to help their children.

The school's basic objective is to help each child develop as much self-sufficiency as possible. The program for trainable retarded children includes significant amounts of physical-motor development, language development, socialization, activities of daily living, recreation, and vocational training (see Chap. 11 on vocational services for a description of the latter program). Most graduates are placed either in jobs or sheltered workshops following graduation; the transition from school to adult life is facilitated as much as possible. The annual operating expenditures for this school are about \$3500 per child.

Variety School.²⁸ The Variety School, also a separate day school, is for special education of physically and multiply handicapped children who are too severely handicapped to be served in a special education classroom in a regular school. The school began as a charitable project of the Variety Club. About 99 of the 156 students are mentally retarded. The school has seven classes for educable mentally retarded children who also have some additional handicap, two classes for trainable or more severely retarded children who are in wheelchairs, four classes for physically handicapped children only, and two special kindergarten classes. The school's operating budget is about \$3500 per child per year. The staff of 58 includes 15 classroom teachers, 2 full-time physical therapists, a speech therapist, an occupational therapist,

²⁷ Information based on an interview with Dr. Robert Foster, Principal of the Helen J. Stewart School, Las Vegas, Nevada, October 25, 1974.

²⁸ Information in this subsection is based on an interview with Principal Howard Marr, Variety School, Las Vegas, Nevada, October 25, 1974 and a letter from Dorothy Seigle, Clark County School District, to James Kakalik, The Rand Corporation, March 9, 1976.

pist, and a social worker, plus a psychologist, a nurse, and a vocational counselor part-time. A school bus provides transportation for students as far away as Boulder City and Henderson (a total of 60 children are bussed to the Helen J. Stewart and Variety Schools from those two cities), but no one from the remote rural areas of Clark County is served. In response to the 1975 state legislature's lowering of the age of special education for mentally retarded children to 3 years old, the Variety School served 36 mentally retarded children aged 3 or 4 years old as of March 1976. With due praise to the high dedication and effort of the staff of the Nevada Mental Health Institute, we note that the overall level of professional preparation of the staff, the quality of the facility, and the comprehensiveness and depth of the service programs for retarded children and youth at the Helen J. Stewart and Variety Schools in Clark County are better than those for retarded residents of the Nevada Mental Health Institute (see Chap. 10 for a description of the Institute).

Douglas County School District

The Douglas County School District has four special education teachers,²⁰ who serve about 43 mentally retarded children.²⁰ One of these teachers works outside the county, at the facility of the Ormsby Association for Retarded Citizens in Carson City; Douglas County sends four of the more retarded children there, and provides a budget of \$24,000. Although more than four children per teacher are allowed by state regulation, Douglas County reportedly does not have a means of identifying additional retarded children to fill the class it funds at the Ormsby ARC facility.²¹

Washoe County School District²²

The Washoe County School District is the second largest in Nevada in terms of population, serving a county with a total population of about 142,000. The great majority live in the urbanized Reno-Sparks area where, with the exception of two teachers at Lake Tahoe, all special education services available in the county are provided. No children are bussed in for special education service from rural areas of Washoe County, and no assistance is provided to other counties. The district provides a comprehensive program of services to educable and trainable mentally retarded children, but admits providing only partial services for emotionally disturbed children.²³ Mentally handicapped children are admitted into the special education program by a certified psychologist or, in the case of retarded children, perhaps by a person serving under the direction of such a psychologist. The specific criteria for an emotionally disturbed child in Washoe County are:

1. The child must be incapable of being educated effectively through regular classroom instruction.
2. A reasonable assumption that the child can benefit from the special facilities available.

²⁰ Nevada Department of Education, "Special Education Units—1973/74," unpublished data, 1974.

²¹ Idem, *Research Bulletin*, Vol. 16, No. 1, January 1974.

²² Interview with S. Landis, Ormsby ARC, Carson City, Nevada, November 15, 1974.

²³ Information in this section is based on interviews with Roy Berry, Director, and Gerald Myers, Coordinator, Special Education Services, plus several special education teachers, Washoe County School District, Reno, Nevada, August 19, 1974, and November 20-21, 1974.

²⁴ Special Education Programs, Washoe County School District, Reno, Nevada, 1974.

3. While the child may be functioning as if retarded, there shall be no diagnosis of mental deficiency.
4. The child's behavior must not constitute a threat to the physical welfare of other students.³⁴

The criterion for a learning disabled child is exhibition of "a disorder in one or more of the basic psychological processes of central-motor, central-perceptual, central cognitive, and/or spoken or written language. These disorders may be manifested in the areas of listening, thinking, talking, reading, writing, spelling or arithmetic." A common element among learning disabled children in Washoe County was said to be a two-year deficit in academic skills.

The criteria for an educable mentally retarded child are:

1. An Intelligence Quotient (I.Q.) score between 55 and 80 on an individually administered, nationally standardized test of intelligence.
2. A Social Maturity Quotient (S.Q.) score between 60 and 80 or a rating by the examiner indicating sufficient social competency to participate in and benefit from a semi-integrated school program.
3. Academic performance at least one standard deviation below that which would be expected of a typical child of comparable age.

For a trainable mentally retarded child the criteria are:

1. An Intelligence Quotient (I.Q.) score between 25 and 55 on a nationally standardized, individually administered test of intelligence.
2. A Social Maturity Quotient (S.Q.) score between 25 and 60 or a rating by the examiner indicating social competency to the extent that the child is capable of cooperating with his teacher and his peers.
3. The child should be ambulatory and toilet trained.
4. The child should have sufficient communication skills to make his needs known.

The maximum number of educable mentally retarded enrollees for instruction at any one time by a certificated teacher varies from 8 children of preschool age to 14 children of high school age. With a teacher's aide, the number of enrollees per teacher can be increased by up to four children. The above numbers also hold for emotionally disturbed and learning disabled enrollees. The maximum number of trainable mentally retarded enrollees for instruction at any one time by a certificated teacher is two less than the maximum for educable mentally retarded children.

The special education program for educable mentally retarded children in Washoe County is typically conducted by "mainstreaming," with the EMR children integrated into regular classes at regular county schools whenever feasible. The EMR children are generally outside the regular classroom at most half of the time, and time for each child (typically, one-fourth of the time) is scheduled in special resource rooms. At the high school age, the program becomes quite vocationally oriented, with many going into a cooperative work-study program (see Chap. 11 for details). Trainable and more severely retarded children who the school district administrators feel do not require "custodial type care" are served at a special

³⁴ Ibid., pp. 6-8, for these and subsequent criteria in this section.

school. A new special school for these retarded children, containing about 10 classrooms with a capacity of 105 children, is being constructed at a cost of approximately \$1.1 million and is scheduled to open in 1975. The county also has a cooperative agreement whereby it receives extra state funding and provides four special education teachers for retarded children from throughout the state who reside at the Nevada Mental Health Institute (see the next section below, "Special Education at the Nevada Mental Health Institute.")

When we asked about special education for emotionally disturbed children in Washoe County, the county's Director of Special Education responded, "We don't have any in this county," which technically is true. The special education program in Washoe County for emotionally disturbed and learning disabled children, who are grouped together for service and called "educationally handicapped," is almost exclusively "mainstreaming," with the children spending most of their time in regular classrooms and a small portion of their time in special resource rooms. The special education coordinator estimated that there are approximately 50 seriously emotionally disturbed children labelled and served as "educationally handicapped." In 1974 the county did not have a teacher certified in the area of special education of emotionally disturbed children. With 50 served, the full-time-equivalent teaching staff would be about four. The special education coordinator also cautioned that care must be taken with "mainstream" programs to see that they are not a "ruse to get more money for doing the same thing they were doing before." In brief, the Washoe County schools provide only about 50 seriously emotionally disturbed children with special educational service, which may or may not be appropriate to their needs. In addition, less than 50 of the most severely emotionally disturbed children were referred to the Reno Mental Health Center for psychological services in 1974.

Interviews with special education teachers for learning disabled children in Reno illustrate how these programs sometimes function.²² One school we visited had a staff of two teachers plus one aide serving 24 learning disabled children on a one-to-one basis. They did so for a maximum of 2½ hours per week per child in a resource room to which the children are sent from the regular classroom where they spend the great majority of their time in the "mainstream" with nonhandicapped children. The special education teachers said most of these learning disabled children were "really just not performing up to snuff." The school has no remedial reading teachers, however; consequently, a child two years behind his or her peers in reading achievement may be labeled "learning disabled" and placed in this program for special tutoring. As one might expect, there is considerable turnover during the year (about 50 percent) among students in the program at this particular school. The children in a learning disability class can range from those with identifiable neurological handicaps to those who are behind in academic skills and need remedial tutoring.

Two of the Washoe County special education units are demonstration classes at the University of Nevada at Reno, serving 8 learning disabled and 7 trainable retarded children.

The certified special education teachers in Washoe County number 104, of whom 99 are funded by the state and 5 by federal money. The district personnel

²² Interviews with teachers of learning disabled children at the E. Gosam School in Reno, Nevada, November 20, 1974.

indicated that a "buyer's market" prevails for teachers and they have no trouble obtaining good special education teachers. Current teachers have an average of about six years experience. There are also about 10 full-time-equivalent special teaching assistants. The school district employs six psychologists at \$20,000 each to perform testing almost exclusively. With 31,000 students, there is one psychologist for approximately every 5,000 enrolled students. The average special education teaching salary in FY 1974 was \$13,306; district personnel averred that the \$14,500 per unit received in FY 1974 from the state about covered direct salary plus materials.²⁶ Numerical data on fringe benefits, transportation, guidance, school operation, and all facility costs are not included in the \$13,306 and were not available since they are part of the general education budget and not accounted for separately for special education teachers. Direct salaries of special education teaching personnel in the 1974-75 school year were thus about \$1.5 million, including about \$100,000 for the special teaching assistants.

Assuming that salaries are about 57 percent of total special education expenses as shown in the best available data—a 1971 study that prorated all Washoe County education expenses in an attempt to estimate special education expenses²⁷—we estimate 1974-75 special education expenditures in Washoe County to be approximately \$2.6 million. That figure would include about \$100,000 for the four units at the Nevada Mental Health Institute. The state provides \$1,435,500 (99 units $\times$ \$14,500 per unit), Title VI of the federal Education of the Handicapped Act provides about \$40,000, Title III of the federal Elementary and Secondary Education Act provides about \$26,000, and local funds make up nearly all the rest of the approximately \$2.6 million expended annually.

In September 1974, exclusive of the Nevada Mental Health Institute, about 100 trainable and 300 educable mentally retarded children received special educational services from a staff of about 36 full-time-equivalent people. About 375 learning disabled children were served by a full-time-equivalent staff of about 36, exclusive of the 50 seriously emotionally disturbed children mentioned earlier. Prorating the total special education budget in proportion to the certified teaching staff yields a 1974-75 school year estimate of \$1,725,000 for Washoe County's special education budget for mentally handicapped children: \$825,000 for retarded children, \$800,000 for learning disabled children, and \$100,000 for seriously emotionally disturbed children.

Washoe County has no overall screening program to detect possible mental disorders in schoolchildren; the only identification is by testing children referred by the regular classroom teachers to special education for service. (See Chap. 6). The waiting list of handicapped children for special education in Washoe County is approximately 100, but according to the special education director that number is inordinately small because the word gets out that there are no vacancies and children cease to be added to the list.

In Washoe County, the county-level staff hires the special education teachers, rather than the local school principal. The county staff also supervises these teachers, unlike the practice in Clark County. However, we learned from professors at the

²⁶ The salary range in FY 1974 was \$8,200 to \$17,250; there is no extra pay for teaching in the special education program.

²⁷ "Washoe County School District Special Education Costs, 1970-1971," unpublished data obtained from G. Myers.

University of Nevada at Reno, and from some local teachers, that the supervision is sometimes minimal. The Washoe County central special education office consists of 2.5 full-time-equivalent personnel, one of whom goes into the field to counsel and supervise the teachers. The philosophy is to let the local special education teachers develop their own programs "unless they get too far out of line."

As far as teacher retraining is concerned, there is voluntary participation in in-service training classes, with one class running at all times. It is a one-hour-a-week, eight-week program that provides teachers with one credit toward salary merit increases. In addition, all special education teachers get together for a meeting one day a year.

SPECIAL EDUCATION AT THE NEVADA MENTAL HEALTH INSTITUTE**

In 1974, four certified teachers and one aide provided special education services to 32 trainable, severely, and profoundly retarded people aged 5 up to 18 from throughout the state who were residents at the Nevada Mental Health Institute. The annual cost was about \$100,000. The special education program is not operated by the Institute, but is under control of the Washoe County School District. No such services are provided in the summer. Retarded residents of other ages at the Institute need similar education and training services, but because they were not of the legal school age they were not served by the education system.

As of June 30, 1974, there were 23 other residents aged 5 up to 18 years who did not receive the services given to their 32 peers.** In other words, though all 55 needed special education and training and such service is mandatory by Nevada state law, less than 60 percent were served, because the state did not provide funds for more than four teachers and because Nevada Department of Education regulations limit the number of children each special education teacher can serve.

The special education and training program at the Institute began only in FY 1974. For several years prior to that time no such services were provided to residents, so considerable progress is being made in program improvement at the Institute.

Teachers set up their own program for each resident served and work with each of them on both a one-to-one and a small-group basis. Instruction covers such items as social skills, physical activity, coordination, feeding and toilet training, language development, and some academic skills for some of the less severely retarded residents. The teachers indicated they feel there is no one they can turn to for guidance on program content, and that their professional training was geared almost exclusively to less severely retarded people than they are presently serving. They were not familiar with the program, and had not met with the staff, of the Helen J. Stewart School in Las Vegas, which also serves more severely retarded children.

The teachers would like to take the residents off the institution's grounds more,

** Material in this section is based on interviews with special education teachers at the Nevada Mental Health Institute, 480 Galletti Way, Sparks, Nevada, November 22, 1974; the above-cited interview with R. Berry and G. Myers; and a letter from T. Piepmeyer, NMHI, Sparks, Nevada, to J. S. Kakalik, The Rand Corporation, Santa Monica, California, February 27, 1976.

** *Rehabilitation Facility Plan—1975-1980*, Nevada Rehabilitation Division, Carson City, Nevada, January 1, 1976, p. 166.

to broaden their experiences and aid in training for "normalization" of their lives, but do not have the transportation to do so.

Teachers report considerable progress now that residents are receiving services they need, although objective evaluation data are not yet available. In the fall of 1974, however, they gave a Social Maturity test to each student and intend to do so each fall and spring in the future.

The teachers indicated very strong feelings that the ward staff level is inadequate, and that ward staff do not follow through on treatment programs and do not fully implement individual treatment plans. It was suggested that ward staff levels be increased and that one person be responsible for running the ward staff meetings on each child, for developing a service plan, and for seeing that it is implemented and enforced.

A primary problem is that the wards do not have enough staff to do all the things the teachers believe they should be doing. The ward staff is supposed to be responsible for feeding training and toilet training, for example, but because they have not adequately handled those functions, the special education teachers were helping them learn the techniques. For about 30 to 60 minutes each afternoon, two teachers worked with ward staff members to get them to follow up on and reinforce the teachers' work.

In early 1976, all residents between 3 and 18 years of age are enrolled in an education program. Only 7 of the 38 residents of those ages attend classes in the Reno community; the remaining children are served on the Institute grounds. There are 5 special education units which are served by 5 special education teachers and 1 teaching assistant. One half-time mental health technician also assists with transporting the nonambulatory clients to school and helps in the school program. Some minimal adult educational services are available for some of the higher functioning clients who are over 18 years of age. There are approximately 20 clients between 18-21 years that are unserved in early 1976. Efforts are now being made to obtain federal educational dollars for this population in cooperation with the state Department of Education and the Washoe County School District.

PRIVATE COMMUNITY TRAINING CENTERS

Several private community training centers in Nevada aid mentally retarded or functionally retarded⁴⁰ persons who are not served by other programs; hence most services in these centers are for preschool children and adults. The centers are partially funded by the Community Training Center program within the Nevada Division of Mental Hygiene and Mental Retardation. They may provide a variety of services, including day-care activities, education, developmental training, individual and family counseling, supervised residential living, and sheltered work.⁴¹ (Education services are described in this chapter; other services by the centers are described in this report's chapters on vocational services and residential living.) The state-provided funding is a minimum of \$300 per enrollee per quarter, the actual

⁴⁰ Defined as a person who "functions like an individual meeting the [AAMD] definition of mental retardation] requirements. See Nevada Division of Mental Hygiene and Mental Retardation, *Operating Regulations for Approved Community Training Center Grantees*, Reno, Nevada, 1974.

⁴¹ *Idem*, *Mental Retardation Services in Nevada*, Reno, Nevada, June 1973.

amount depending on funds available. Each center receives a minimum of \$14,000 per year, provided staff expenses are equal to that amount and they have a minimum of five certified enrollees per quarter. The state has paid a maximum of \$350 per enrollee per quarter in large centers and a maximum of \$15,000 per annum in small centers. In addition to the centers described below, a new satellite center recently opened in Gerlach-Empire and serves 8 preschoolers.⁴³ To be eligible for funding, the centers also must have a minimum staff of one person for each group of five retarded persons or major fraction thereof. Centers must certify why each enrollee is not in a local school program (e.g., "not of school age"). The centers must provide service a minimum of six hours a day, five days a week, 240 days a year, excluding holidays and one day a month for staff development.⁴⁴

Currently, about 70 preschool and school-age mentally or functionally retarded children are provided education and training services in six community training centers. The full-time-equivalent staff for these children is approximately 14. Assuming an annual operating cost of at least \$2400 per enrollee, the annual expenditures for these retarded children are at least \$168,000. The Community Training Centers program is collecting about \$75,000 per annum in federal Title XX social services funds.⁴⁵

The numbers of people served in programs of the various community training centers are described below.

The *Elko Developmental School* serves 11 people. It is primarily a preschool directed by a certified special education teacher, but it also operates a small sheltered workshop.⁴⁶

The *Mineral County Sheltered Workshop* serves approximately 13 people. It is primarily a preschool, and secondarily a prevocational and vocational program for retarded adolescents and adults. The program is directed by a special education teacher, assisted by two half-time teaching aides and volunteers.⁴⁷

In the past, the *Opportunity Village Association for Retarded Citizens* operated a school for severely retarded children who were not served by the public school system. As special education services expanded in Clark County public schools, the Opportunity Village school program was phased out. In historical sequence, there was a need filled by the private sector followed by application of pressure on the public school sector to recognize the right of handicapped children to have an education, and finally, gradual inclusion of the services in the public school sector.⁴⁸

The *Ormsby Association for Retarded Citizens* served 12 children and 8 adults in November 1974 with a staff of 18, including a social worker, a half-time speech therapist, a part-time physical therapist, two teachers, one teacher's aide, and volun-

⁴³ NRS 435.240 and 435.290 as amended by SB374 and SB298, respectively, 1976, and a letter from J. Middleton, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, to J. S. Kakalik, The Rand Corporation, Santa Monica, California, February 10, 1976.

⁴⁴ Nevada Division of Mental Hygiene and Mental Retardation, *Operating Regulations . . .*

⁴⁵ The \$2400 figure is obtained assuming an average salary of \$10,000 a year divided by the five children: maximum per staff member, plus \$400 for other direct operating expenses. This excludes all facility costs and hence is a low estimate. Information on the Title XX Funds was provided by J. Middleton, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, February 10, 1976.

⁴⁶ Interview with M. Carroll, Community Training Center Coordinator, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, October 7, 1974.

⁴⁷ Ibid.

⁴⁸ Interview with Dr. T. Johnson, Executive Director, Opportunity Village Association for Retarded Citizens, Las Vegas, Nevada, July 17, 1974.

teers.⁴⁸ Although the center is in Carson City, which is in Ormsby County, adjoining Douglas County provides \$24,000 annually and one special education teacher for the center, and sends four retarded children of school age. In addition to serving school age children, the Ormsby center operates a preschool program for children who are too young for attendance in public school or who are functioning at a developmental level inappropriate to a classroom situation.⁴⁹ The center provides transportation.

The *Panaca Community Training Center* is primarily a sheltered workshop and training facility for retarded people beyond school age, although one preschool-age child was being served in late 1974. At the time we obtained this information, an attempt was being made to have the child served in a more appropriate school setting.⁵⁰

In 1973 the *Washoe Association for Retarded Citizens* phased out the child development center for mentally retarded children it formerly operated, as the local school district accepted the responsibility for serving those children.⁵¹

The *White Pine County Rehabilitation Center* is a daily living and prevocational skills training center for developmentally disabled adults, although in late 1974 one 14-year-old was attending. The child was not in public school because of a conflict between the child's family and the school. According to the state Community Training Center Coordinator, there is no appropriate service program in Ely for that child.⁵²

The *Zion Methodist Day Nursery*,⁵³ a preschool program in Las Vegas, integrates functionally retarded and some mentally retarded children with nonhandicapped children, and also supplements the retarded children's preschool program with some small-group work. The day nursery serves approximately 150 children (handicapped and nonhandicapped) with a staff of 14 teachers and 10 foster grandparents. Most of the teachers have no formal training in education. Of the 150 children, 38 are diagnosed as "functionally mentally retarded." Rediagnosis takes place once a year.

Child's World, a private day-care and training program for both preschool-age handicapped and nonhandicapped children sponsored by the Economic Opportunity Board of Washoe County, served 9 mentally retarded children in 1974. It did not receive funding from the state Community Training Centers program in 1974, and was closed in July 1975.⁵⁴

SPECIAL CHILDREN'S CLINICS: PRESCHOOL EDUCATION

The two Nevada Division of Health Special Children's Clinics for young men-

⁴⁸ Interview with S. Landis, Ormsby Association for Retarded Citizens, Carson City, Nevada, November 15, 1974.

⁴⁹ Description of Community Training Center Program, Ormsby Association for Retarded Citizens Developmental Center, submitted to the Nevada Division of Mental Hygiene and Mental Retardation, 1974.

⁵⁰ Interview with M. Carroll.

⁵¹ Interview with M. Wedge, Washoe Association for Retarded Citizens, Reno, Nevada, May 10, 1974.

⁵² Interview with M. Carroll.

⁵³ Interview with M. Bennett, Zion Methodist Day Nursery, Las Vegas, Nevada, October 26, 1974.

⁵⁴ Nevada Rehabilitation Division, *Rehabilitation Facility Plan—1975-1980*, Carson City, Nevada, January 1, 1975, and a letter from J. Middleton, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, to J. S. Kakalik, The Rand Corporation, Santa Monica, California, February 10, 1976.

tally retarded children provide diagnosis, counseling, and direction services, and each also operates a nursery school and an infant stimulation program.**

Each clinic runs a part-day nursery school to which children diagnosed as needing its services are referred. The nursery schools served about 20 children each in 1974, 10 in the morning and 10 in the afternoon, for about two-hour sessions. As can easily be imagined, the waiting lists were long in 1974, since the public schools did not serve preschoolers prior to the fall of 1975 (except for a few at the Helen J. Stewart School in Las Vegas). In March 1976, the Washoe County School District was supplying one additional teacher for a cooperative preschool program located at the Northern Nevada Special Children's Clinic, and the Southern Nevada Special Children's Clinic was phasing its 3 and 4 years old preschoolers into the Clark County school system. The 1976 Northern Nevada Special Children's Clinic nursery school, and both the Northern and Southern clinics' infant stimulation programs use their personnel not only to help the child, but also to train the child's parents. Thus, parents learn how best to help their retarded child, while the clinic makes the maximum use of its limited teaching resources.

As currently established, with the exception of the traveling diagnostic team (described in Chap. 6) both clinics' preschool programs effectively are limited to Reno and Las Vegas residents. The operating expenditures for the clinics' preschools are not itemized separately in their budgetary material, but assuming they are approximately the same per unit (professional) as the average of the Clark and Washoe County school district expenditures, the two clinics expended approximately \$53,000 on the preschool program in FY 1974.

NEEDED IMPROVEMENTS IN SPECIAL EDUCATION AND TRAINING PROGRAMS

Problems

Although Nevada's special education and training programs are improving, several problems with those services for mentally handicapped children and youth can be identified from inspection of the program descriptions presented earlier in this chapter. They include insufficient funding and service (less than half of those conservatively estimated to be in need are served); inequities in service by type of mental handicap (services specifically for seriously emotionally disturbed children are nonexistent in most Nevada counties and are provided to a token number in a very few other counties); a questionable allocation of about half of the limited available special education resources for services to mentally handicapped people to people with the generally less severe "educational handicaps"; differential service by sex (boys outnumber girls in special education in Nevada two to one, and we seriously question whether there are twice as many handicapped boys as handicapped girls in the general Nevada population); and inequities in service by geogra-

** Information in this section is based on interviews with Drs. J. Ashbeagh and J. Edwards, Directors of the Southern and Northern Nevada Special Children's Clinics, respectively, 1974, on a letter from J. Edwards to The Rand Corporation, Santa Monica, California, February 26, 1976, and on a letter from J. Owen, Director, Southern Nevada Special Children's Clinic, Las Vegas, Nevada, to The Rand Corporation, Santa Monica, California, February 27, 1976.

phy (for all handicapped children in the remoter rural areas of every county, and for trainable and more severely mentally retarded children in the entirety of all but a few counties). These problems also include insufficient attention to the transition from school to adult services (e.g., to the Vocational Rehabilitation program if those services are needed); lack of programs in schools for identification of all mentally handicapped children needing services (none of the three largest school districts, which contain three-quarters of the state's school-age population, has a screening program reaching all children); lack of direction to other service providers (see Chap. 4); and lack of information (at the state level, even the number of mentally handicapped children in special education is not accurately known, and quantitative data on the effectiveness of Nevada's special education are virtually nonexistent). Finally, there is a problem of an inadequate number of professional staff to manage the special education program at the state level (only two consultants), and of triplication of preschool education responsibility at the state level (among the Department of Education, the Division of Health, and the Division of Mental Hygiene and Mental Retardation). Of all the problems listed, the greatest by far is the large fraction of seriously emotionally disturbed and mentally retarded children who receive no special education at all.

Special Education and Training Recommendations

The primary concern, then, is to expand special education services and make them available to all seriously emotionally disturbed and all mentally retarded children and youth who need them, as is required by law. It may clarify the following discussion if we mention two factors that will not impede that expansion.

First, the major current factors limiting expansion of services do not include the inability to hire qualified special education teachers. Although the problem is more difficult in rural counties, administrators we interviewed in the larger counties (with over three-quarters of the population) and in rural Churchill County said they had no difficulty in hiring special educators.

Second, the major factors limiting service do not include insufficient dollars per special education unit supplied by the state; the financial incentive was strong enough to induce the counties to use all available units when \$14,500 was supplied per unit, and the amount was raised to \$16,000 in 1975.⁶⁶ The average annual operating expenses shown in Table 7.1 are approximately \$27,000 per special education unit (professional). Since the \$11,000 difference between \$16,000 and \$27,000 is about \$1000 per handicapped child served by the unit,⁶⁷ or about the same as the \$1009 expense of regular education per child in FY 1974 in Nevada,⁶⁸ the state is already paying to the counties approximately the average added expense of special education for a mentally handicapped child above the expense of regular education

⁶⁶ Washoe County officials we interviewed claim their county does not establish additional special education units using county funds exclusively because of strong budget pressures in other areas, a situation that we suspect exists in most Nevada school districts. One pressure mentioned was the demand by the strong Washoe County teachers' organization for salary increases.

⁶⁷ The average number of special education students per unit is about 11. See Table 7.1.

⁶⁸ Governor M. O'Callaghan, *Message to the Legislature of Nevada—Fifty-eighth Session*, Carson City, Nevada, January 21, 1975.

for a nonhandicapped child. Consequently, we do not recommend increasing the \$16,000 per unit state support level, except as future inflation may require.⁵⁵

In our view, the two factors most responsible for restricting the number of mentally handicapped children receiving special education are: (1) the limited number of units for which the state will provide financial support, and (2) the lack of identification programs for mentally handicapped children in the county school districts.

We reiterate our Chap. 6 recommendation that a comprehensive screening program be established in every county school district to identify all mentally retarded and seriously emotionally disturbed children in need of special education services. Obviously, a school district cannot serve mentally handicapped children if it does not know who they are. Churchill County already has a commendable screening program for every child entering the school system (both kindergarteners and transferees). We suggest that the identification program reach all children first entering the school, and provide for a one-time review of all children when they reach a selected elementary school age (perhaps 7 or 8 or 9 years old) to identify any who were missed earlier or whose mental problems developed in the intervening years. See Chap. 6 for details. The tertiary prevention of mental handicaps by providing early special education is discussed in Chap. 5.

In FY 1974, the enrollment by sex in special education was 2271 males and 1152 females.⁵⁶ The total school population in the state is split about evenly between boys and girls; we seriously question whether the 2 to 1 ratio of boys to girls in special education reflects the actual prevalence of handicapping conditions in children. Perhaps handicapped boys are more likely to be "trouble makers" in class than handicapped girls are, and hence the regular teacher is more likely to refer them for special education. The improved identification program we recommend should enable school officials to halt any sex discrimination that may be afoot.

We recommend that the state finance an additional 230 special education units above FY 1974 levels specifically for seriously emotionally disturbed children, and an additional 163 units specifically for mentally retarded children. This would furnish special education to a total of 2650 seriously emotionally disturbed children and 3030 mentally retarded children, with the same average teacher-to-student ratio shown in Table 7.1. If more or less than those numbers of handicapped children are identified by the screening program we have recommended, the number of special education units can be adjusted accordingly. While it is desirable to place a ceiling on the number of units to prevent unnecessary labeling of children who do not have substantial handicaps, and to control costs, the Nevada Legislature has been ambivalent in mandating special education for all handicapped children but failing to allocate funds to cover the expense. The legislature did significantly increase the number of units in 1975, however, and thus continued the growth of the special education system. Since special education of all handicapped children is legally required in Nevada, we suggest a state goal of having every handicapped youth in special education by 1980. While spreading the action over a five-year period does

⁵⁵ The alternative mechanism of having the state pay the exact amount of added costs of special education above the cost of regular education is not endorsed because of the expense and red tape of the separate accounting system that would be required, and because it is felt that some counties might load the special education budget with overhead.

⁵⁶ Nevada Department of Education, *Research Bulletin*, Vol. 16, No. 1, January 1974.

not solve the problem of unmet needs immediately, it will allow time to identify the children in need, to modify facilities and retrain personnel, to hire high-quality new special education teachers, and to develop transportation. (A lawsuit also has been filed in Nevada to force the provision of special education to all handicapped children; this is essentially the same lawsuit that has been won in other states on constitutional grounds.)⁴¹

Inequities in service by type of handicap may be only partially resolved by increasing the number of units funded. Under current definitions used in Nevada education, children with significantly different service needs are lumped together under the term "educationally handicapped." The term is so broad that large numbers of children could find themselves labeled unnecessarily, and many children who do not have substantial handicaps (e.g., children who need only remedial reading) might be placed in special education, while those with substantial handicaps might go unidentified and unserved if funds are not earmarked for them. *We recommend that the definitions of handicapping conditions issued by the Nevada Department of Education be made more specific, that limits be placed on the number of units by type of handicap, including seriously emotionally disturbed children as a separate category, and that all special education standards be enforced.*

We recommend that the special education staff of the Nevada Department of Education be significantly increased to at least 10 full-time-equivalent professional staff members so that they can adequately provide guidance and consultative technical assistance to rural county school districts, and so that they can adequately manage their major responsibilities in the area of special education. The two consultants who currently make up the state special education professional staff are to be commended for the fine job they are performing, but they are only human; a much larger staff is needed.

Since it is not reasonable to expect the rural school districts to have, on their full-time county staffs, all of the specialized and expensive special education expertise they may need, the Nevada Department of Education should provide for consultation and technical assistance to rural special educators.

Specifically, we recommend three teams be created with Department of Education funding to provide consultative technical assistance to special education personnel in rural Nevada. Two of the teams would be based in Reno and Las Vegas so as to tap the professional talent available at the university and elsewhere in those two cities; they would serve rural areas in northwestern and southern Nevada. The third team would provide consultative assistance to rural eastern Nevada counties; it might be based at a Special Education Center in, say, Elko or Ely; one center with a well-trained and specialized staff in rural Nevada would be preferable to several poorly staffed ones. Staff at these centers could provide consultation upon request by rural county school districts regarding such matters as diagnostics and planning for individual children, and special education methods and materials. They could also provide in-service training for local special educators.

Some of this consultation service is already provided, but not on a long-term basis with stable funding. For example, University of Nevada professors report

⁴¹ See L. Lippman et al., *Right to Education: Anatomy of the Pennsylvania Case and Its Implications for Handicapped Children*, Teachers College Series in Special Education, Columbia University, New York, 1973; and A. Abeson et al., *A Continuing Summary of Pending and Completed Litigation Regarding Education of Handicapped Children*, Council for Exceptional Children, Reston, Virginia, No. 8, December 31, 1974.

enthusiastic response to three- or four-day short courses followed by assignments and a return visit in about a month.⁴² Summer traineeships and workshops are also available. On a more regular basis, the University of Nevada at Reno has a full-time "circuit-rider" who provides special education consultation services to teachers in several rural northern Nevada counties. He works with the teachers, only on referrals through school principals, in setting up programs for individual children; he also provides some special education materials.⁴³ Although federally funded, he is really doing work that the Nevada Department of Education could provide on a long-term basis for all rural Nevada counties. He assists not only special education teachers, but also some regular education teachers. For example, one school he assists consists of a regular teacher, seven nonhandicapped students, and one handicapped student attending in a house trailer that also serves as the teacher's residence. The "circuit-rider" returns regularly to do follow-up with the teachers he assists, and sees a teacher one to three times every two months. Regarding areas of deficiency in rural special education, he noted the problems of serving severely handicapped children, and the fact that there is essentially no service for emotionally disturbed children.⁴⁴

For the most severely handicapped children, the highly specialized programs and personnel needed generally are not now available in rural Nevada. Since only a small number of such children are to be found in any given rural area, and specialized personnel to serve them are scarce, it would be expensive to provide a high-quality program for all types of severely handicapped children in each rural county. In practical terms, the family that wants high-quality specialized services for their severely handicapped child may be better off moving to Reno or Las Vegas if it is feasible for them to do so; or if the family lives in a county near Reno or Las Vegas, perhaps the child could go to one of those cities for schooling and return home each weekend.

In-service training and advice to rural special education teachers can also be given by means of telephone and television (regular TV, two-way videotelephone, or video tape). The exemplary Helen J. Stewart special school in Las Vegas, for example, has videotape equipment and taped materials for use in the special education training of teachers of trainable severely and profoundly retarded children. Copies could be made at relatively low cost for use in staff and parent training in rural areas, which thereby could capitalize on the specialized knowledge available in the larger Clark County school system. The Nevada Department of Education could provide funds and staff to disseminate these materials and to prepare additional ones. After an in-service training class has viewed a videotaped lesson, a professor at the University of Nevada or some other special education specialist could answer their questions by telephone.

For education and training of mentally retarded persons at the Nevada Mental Health Institute, we recommend that (1) nearly all mentally retarded residents be provided special education and training services appropriate to their level of development; (2) those special education and training services be provided away from the institutional setting for nearly all residents; and (3) a teaching aide and adequate equipment and materials be provided for each special teacher. The present numbers

⁴² Interview with Prof. W. Wagonseller, University of Nevada, Las Vegas, October 24, 1974.

⁴³ Interview with W. Green, University of Nevada, Reno, November 21, 1974.

⁴⁴ Ibid.

of teachers, aides, equipment, and materials are inadequate in relation to the clear need. Service away from the institutional setting would enhance the education, training, and quality of life of residents by giving them wider exposure to the normal situations and experiences of everyday life.

The Community Training Center program as presently operated is a dichotomous entity that provides two basically different kinds of service to mentally retarded people: a preschool program, and a day care, activities of daily living, prevocational, and vocational (including sheltered work) program for the more severely mentally retarded people about age 18 or above.

Since the age range for mandatory special education of mentally retarded children by the public school system was lowered to age 3 in 1975 by the Nevada Legislature, we recommend that the preschool portion of the CTC program in rural areas focus on developmental stimulation and training for the more severely retarded children below age 3 only. In the Las Vegas and Reno areas, we recommend that the Community Training Centers serve only adults, leaving developmental stimulation and training for the more severely retarded children below age 3 to the Special Children's Clinics. These changes in focus will decrease the present fragmentation and triplication of responsibility for preschool special education and training programs.

For the CTC program, we estimate the cost per enrollee per year to provide minimum quality services is currently two to four times as high as the minimum level of funding per client the CTC program provides.⁶⁶ However, primary funding for some clients at these centers is provided by a county school district or by the Vocational Rehabilitation program. We recommend that the Community Training Center minimum funding level per enrollee be at least doubled for those clients not primarily funded by some other agency.

The Nevada Division of Health's Special Children's Clinic program presently operates two small nursery schools and infant stimulation programs, primarily for mentally retarded preschool children who were not served by the county school districts in FY 1974. Since the Nevada Department of Education, as a result of 1975 legislation, requires the special education by public schools of 3- and 4-year-old mentally retarded children, we recommend that the Special Children's Clinics program transfer their nursery school children of those ages to the county school districts and concentrate their very limited resources on identification of preschool-age retarded children, direction of their families to other service providers, counseling of families with retarded children, and developmental stimulation and training for the more severely mentally retarded children below age 3.

The parents of retarded preschool children are a potential source of developmental training assistance. To make the maximum use of limited teaching resources, and to help the parents learn how best to help their retarded children develop, each preschool special education and training program for retarded children might also offer training for parents. The northern Nevada Special Children's Clinic is already doing this with apparent high success; it could be extended, and parents could be a source of assistance in the classroom during their training.

⁶⁶ Funding is a minimum of \$1200 per enrollee per year (\$300 per quarter), while the staff-to-enrollee ratio must be 1 to 5 or better. If the average staff salary is only \$10,000 per year, the salary cost alone per enrollee is \$2000 per year. The Nevada Association for Retarded Citizens estimates that the present CTC funding covers only 19 percent of the cost (as reported in "Retarded Patients to Attend Hearing," Nevada State Journal, March 19, 1975).

Regarding interaction of education with other service programs, we recommend improved referral from special education to other programs serving mentally handicapped children and youth. In particular, we recommend increasing the number of referrals to Vocational Rehabilitation of mentally handicapped youth well before they leave school, and increasing the number of referrals of seriously emotionally disturbed children and youth (whether or not they are in special education) to the local mental health center, rural mental health clinic, or Children's Behavioral Services program. The schools are not designed to provide every type of service well, nor should they be, since other programs exist to provide those services. These referrals could all be made and followed up by Direction Centers, if they existed. In the event that other programs do not have adequate resources to serve all those in need of service, then priorities should be established and all referred youth should be screened so that high priority needs are met first.

Because available information on special education and training in Nevada is inadequate for effective program management, accountability, evaluation, and planning (recall that we are not even sure exactly how many mentally handicapped children are in special education), we recommend that improved program management and effectiveness information be obtained for each Nevada special education and training program. With available data, it is not possible to say precisely how much different children benefit from special education, or what the returns per dollar expended are for different types of mentally handicapped youth in Nevada.

Looking at the four basic options displayed in Table 7.5, note that if Nevada does no more than maintain, until 1985, the status quo level and quality of special

Table 7.5

ALTERNATIVE SPECIAL EDUCATION SERVICE LEVELS FOR MENTALLY HANDICAPPED NEVADANS, 1974 AND 1985

Number Served and Expenditures	Status Quo		Reallocation of Resources		Geographic Equity		Minimal Need	
	Maintain 1974 level of services per capita		Shift status quo level of resources among and within programs		Raise level of services per capita in each of three regions to level of best-served region		Provide current quality services in each program to meet conserva- tively estimated need per capita	
	1974	1985	1974	1985	1974	1985	1974	1985
Number served								
Mental health (emotionally disturbed)	100	133	100	133	214	298	2650	3520
Mental retardation	1644	2186	1644	2186	2113	2800	3030	4030
Substance abuse	0	0	0	0	0	0	0	0
Other mental (educa- tionally handicapped)	1987	2640	1987	2640	1987	2640	1987	2640
Total	3731	4959	3731	4959	4314	5738	7667	10190
Expenditures^a (in \$ million)	\$9.346	\$12.43	\$9.346	\$12.43	\$10.13	\$13.50	\$19.70	\$26.20

^aThese are total expenditures for regular and special education and training of mentally handicapped children; they are not solely expenditures above those that would be made for regular education of these children if they were not mentally handicapped.

education and training services per capita and the same programs, the expenditures will rise from \$9.3 million to \$12.4 million per year (see Table 7.5). There are several ways to implement the option of reallocating resources within and among the special education and training programs without increasing total annual expenditures beyond the status quo. The example shown in the table indicates no major change in the number of each type of children served; this would allow implementation of several of our relatively inexpensive recommendations. Another example, not shown in the table, might result from state or local decisions to shift some existing special education funding from, perhaps, educationally handicapped to seriously emotionally disturbed or mentally retarded children. The geographic equity option of raising the level of service per capita of emotionally disturbed and mentally retarded children in each program in each of the three major regions (Clark, Washoe, and all other counties combined) to the level prevailing in the region with the best service would result in about an 11 percent increase in expenditures. The minimal need option assumes implementation of all our recommendations; and gross expenditures for all regular and special education and training services for these mentally handicapped youth roughly double in that option (from \$9.3 million to \$19.7 million⁸⁸), primarily because so many mentally handicapped children in need of special education and training are not being provided any special services now. Thus, the estimated gross annual increase in education and training expenses for these children would be \$10.4 million. The estimated net increase in total expenditures for educating these mentally handicapped children would be an estimated \$6.6 million per year above FY 1974 expenditures, after deducting regular education expenditures that would no longer be required for these children. The annual total education expenditures to meet the minimal need would rise with population growth to about \$26 million in 1985 (in 1974-value dollars).

⁸⁸ The cost of implementing the identification recommendation is counted in the identification chapter, and is not included in the total here.

Chapter 8

NONRESIDENTIAL MENTAL HEALTH SERVICES

INTRODUCTION

Nonresidential mental health services discussed in this chapter include outpatient, emergency care, and day-treatment psychological services. They are delivered in Nevada primarily through mental health centers, Children's Behavioral Services programs, Rural Clinics, Suicide Prevention and Crisis Call lines, by psychological counselors in schools, by the Air Force and Veterans Administration, and by psychiatrists and psychologists in private practice. Residential treatment services for mental health disorders are discussed in Chap. 10. Some people receive nonresidential mental health services following 24-hour inpatient treatment at the Nevada Mental Health Institute (NMHI); not a major program in 1974, it is described in the section of Chap. 10 on mental health services at the Institute.

In this chapter, we first present an overview of nonresidential mental health services in Nevada, and then present details of each of those Nevada programs and their problems. Following that, we discuss Nevada's programs in relation to desirable features of a mental health service system. Basically, we take the eclectic position that people experience a variety of kinds of mental health problems which should be dealt with by a variety of kinds of professionals and paraprofessionals in the least restrictive environment possible, employing a variety of approaches and treatment modalities as appropriate to the particular individual's problems. Our orientation is that no one single modality or approach is the best for every client, and hence no one (such as drug therapy or behavior modification) should be used almost exclusively by a mental health service agency. We conclude this chapter with recommendations for improvement.

We have estimated that in 1975, at least 11,000 Nevadans had significant mental health disorders that result in a substantial need for psychological or psychiatric services. That figure is a conservative *minimum* estimate; the true figure may be as much as five times that, or 55,000 people. (See Chap. 3 for definitions and prevalence data.) The major nonresidential mental health service programs intended to meet those needs, as shown in Fig. 8.1, are operated by professionals in the private sector, by the Nevada Division of Mental Hygiene and Mental Retardation, by the Nevada Health Division, by Nevada education agencies, and by the Federal Government. Some of the programs shown in the figure are small components of larger agencies whose primary concern is not mental health services, such as those serving Indians and mentally retarded people. The two predominant segments of the nonresidential mental health service system intended to meet those needs are the private psychiatrists and psychologists, and the Nevada Division of Mental Hygiene and Mental Retardation.

Table 8.1 is a summary of the FY 1974 estimated caseload, staff, and expenditures for these nonresidential mental health service programs. A total staff of about 171 people provided services in person to a maximum caseload of about 10,500; another approximately 6800 callers to Suicide Prevention and Crisis Call Centers

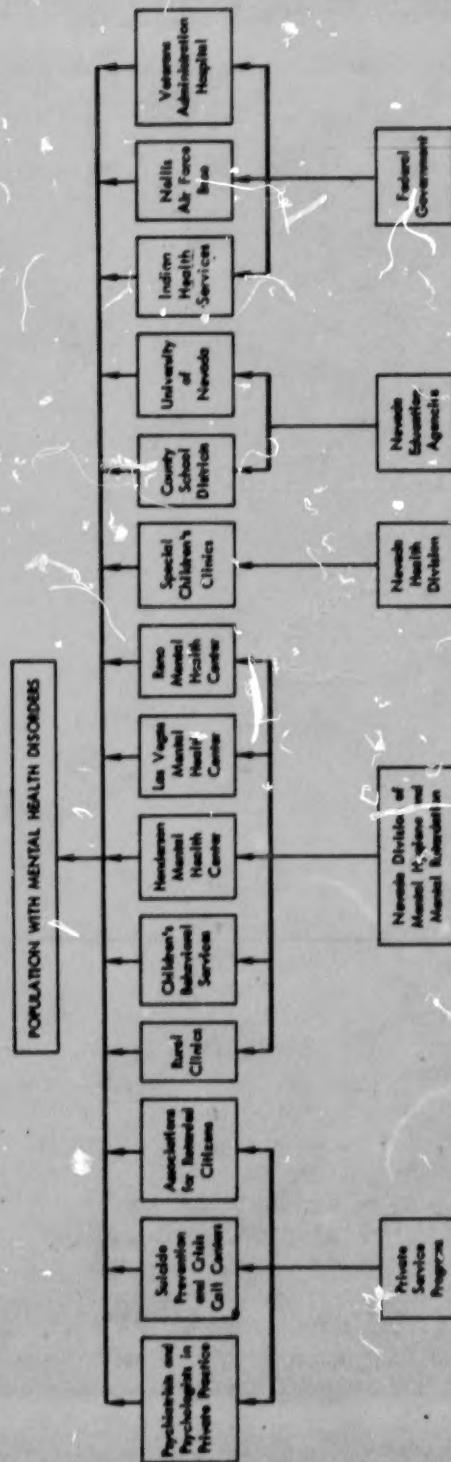


Fig. 8.1—Organization of major nonresidential mental health service programs in Nevada

Table 8.1

**SUMMARY OF MAJOR NONRESIDENTIAL MENTAL HEALTH SERVICES
IN NEVADA, FY 1974**

Program	Estimated Caseload	Estimated Total Staff (full-time equivalent)	Estimated Annual Expenditures
Las Vegas Mental Health Center	2,184	44	\$582,000
Henderson Mental Health Center	570	6.5	\$128,000
Reno Mental Health Center	900	23.5	\$275,000
Rural Clinics	1,200	23	\$443,000
Children's Behavioral Services	600	17	\$168,000
MH service programs in education agencies	700	<9	<\$150,000
Private psychiatrists and psychologists	4,200	26 ^a	\$1,400,000
Suicide Prevention and Crisis Call Centers	6,780 ^b	20	\$12,000
Federally operated programs for Indians and the military	NA	NA	NA
MH service programs for mentally retarded people	<100	<2	<\$50,000
	<10,454 served		
Total	in person ^c	171	\$3,308,000

NOTES: See text of chapter for sources of data and methods of estimation.

NA = not available.

^aProfessionals only.

^bIncludes all people served, some fraction of whom do not have substantial mental health disorders.

^cIncludes an unknown amount of double-counting due to people admitted to a program more than once or admitted to more than one program in a year.

were served by telephone. To some degree, however, these numbers represent apparent rather than actual achievement for the mental health service system. For reasons given immediately below, the number of *different people with mental health disorders* served in person in FY 1974 is significantly less than 10,500; one cannot conclude that nearly all 11,000 people needing substantial psychological or psychiatric services (our minimum estimate) are being served. The 10,500 figure is a count of the number of cases served by the various agencies, and includes: double-counting if people were served by more than one agency in a year or were admitted to the same agency's program more than once; counting of people served who do not have substantial mental health disorders (e.g., some parent-effectiveness trainees in the Children's Behavioral Services program, some consciousness-raising group participants at the University of Nevada, some mildly neurotic people served by private professionals, and various types of people served by Rural Clinics, such as those receiving premarital counseling); and counting of people who are not really served (e.g., those who are counted as cases but who do not return after an initial intake interview—33 percent of outpatient cases at the Las Vegas Mental Health Center are of this type). Finally, cases reported by the agencies may represent people served who have substantial mental health disorders, but who were inappropriately served

due to nonexistence of a service they needed such as day treatment, or inadequately served by a relatively unskilled and untrained mental health technician.

We could not accurately determine what fraction of the 10,500 cases reported as served by the programs represented different people with substantial mental health disorders who were adequately served, so we have reported the maximum 10,500 figure and caution the reader as to its meaning.

Table 8.2 presents the estimated caseloads for nonresidential mental health services in the three major areas of the state. There is a major difference in the total amount of nonresidential mental health service delivery per capita by geographic region; rural counties have a combined public and private caseload of about 11 per 1000 population, Clark County has about 17 per 1000, and Washoe County has about 26 per 1000. The relatively underserved rural areas of the state receive almost no service from private psychiatrists and psychologists; most of the service that is provided comes from the state Rural Clinics mental health program, which has a seriously deficient staff. Clark County is better served on a cases-per-capita basis, and Washoe County is best of the three by far on that same measure. However, that measure does not reveal the fact that in Washoe County the mental health center provides only a limited range of services that are not appropriate for all persons' needs; it does not provide a needed day treatment program or 24-hours-a-day emergency care, for example. This major difference in the level of service per capita in

Table 8.2

NONRESIDENTIAL MENTAL HEALTH SERVICES IN NEVADA BY GEOGRAPHIC AREA,
FY 1974 ESTIMATED CASELOADS

Program	Clark County		Washoe County		All Other Counties Combined	
	Total	Per 1000 Population	Total	Per 1000 Population	Total	Per 1000 Population
Las Vegas MHC	2184	6.9	0	0	0	0
Henderson MHC	070	1.8	0	0	0	0
Reno MHC	0	0	900	6.5	0	0
Rural Clinics	0	0	0	0	1200	10.5
Children's Behavioral Services	600	1.9	0	0	0	0
MH service programs in education agencies	380	1.2	300	2.2	20	0.2
Private psychiatrists and psychologists	1800	5.7	2400	17.3	0	0
Suicide Prevention and Crisis Call Centers	2190	6.9	4590	33	0	0
Federally operated programs for Indians and the military	NA	NA	NA	NA	NA	NA
MH services for mentally retarded people	<50	<1	<50	<1	0	0
Total in-person caseload ^a	<3580	<17.5	<3650	<26	<1220	<10.7

NOTES: See text of chapter for sources of data. NA = not available.

^aIncludes an unknown amount of double-counting due to people admitted to a program more than once or admitted to more than one program in a year.

different geographic regions also exists in the public service system considered by itself, despite the fact that the public service system is state operated.

We now consider each of Nevada's nonresidential mental health service programs and their problems.

LAS VEGAS MENTAL HEALTH CENTER

A major advance in mental health services delivery in the last decade has been the community mental health center (CMHC) movement. Here, as in many other service areas, the intentions of many of those involved in the CMHC movement have been well enough articulated in principle; however, the actual implementation of many of the CMHCs nationwide has differed from the basic principles upon which the movement was based. In principle, a CMHC is to accomplish the following:

- Create local community-based, complementary service alternatives to state mental hospitals.
- Serve all citizens in need in the community, especially poor people for whom private mental health services have been nonexistent or out of reach financially.
- Provide a full range of treatment services, e.g., emergency care available 24 hours a day, inpatient care, day care, partial hospitalization, and outpatient care.
- Create and implement preventive and indirect services, e.g., public education and consultation to other social service providers.
- Integration of mental health services and services with the other elements of the social service system.

Of these programs called mental health centers in Nevada, only the Las Vegas MHC comes close to being a full-fledged CMHC; the Henderson and Reno MHCs do not even provide a full range of treatment services.

The Las Vegas MHC does provide the full range, including inpatient services to adults and to adolescents over age 12. That residential service is discussed in Chap. 10 in the context of other residential mental health services in Nevada. Las Vegas MHC outpatient, emergency, day-treatment ("partial hospitalization"), and consultation and education services are discussed in this chapter.¹

The catchment area "officially" served by the Las Vegas MHC is the western portion of Clark County including the west census tracts of Las Vegas, as well as the towns of Indian Springs, Arden, Goodsprings, and Mesquite. The population in the Las Vegas MHC catchment area is about 165,000, less than half that of the Henderson MHC catchment area. Since the Henderson MHC is very small, it does not offer the complete range of services that the Las Vegas MHC does; in fact, approximately 70 percent of the people served by the Las Vegas MHC actually live in the Henderson MHC catchment area.

The FY 1974 actual expenditures by the Las Vegas MHC were \$1,132,000. The

¹ Unless otherwise noted, information in this section was obtained during interviews with Dr. L. Miller, T. Burke, and various other staff members and patients of the Las Vegas MHC, Las Vegas, Nevada, in March, July, and August 1974, and from a letter from L. Miller to J. B. Kakalik, The Rand Corporation, Santa Monica, California, February 27, 1976.

FY 1975 working budget was about \$1.9 million, with a staff of 115.³ Most of the difference in expenditures between the two years was due to the fact that the center's staff was not complete in FY 1974; even at the end of FY 1974 the staff actually numbered 90, i.e., only about 80 percent of the authorized staff positions were filled. No new positions were authorized by the 1975 session of the Nevada Legislature. The February 1976 actual staff size was 110.

Of the total staff and budget for the Las Vegas MHC, we estimate in Chap. 10 that about 46 staff members and \$550,000 were devoted to residential treatment in FY 1974. Total FY 1974 inpatient admissions were approximately 50 adolescents and 600 adults.

Approximately \$900,000 of the FY 1975 Las Vegas MHC funds came from the Federal Government. The funds were part of an 8-year federal CMHC grant that began in October 1973. As time progresses, the grant pays a decreasing percentage of salary costs of most of the center's employees (dropping from 75 percent in the first two years of the grant to 30 percent in the last four years).

The 31.5 authorized professional service staff positions at the Las Vegas MHC include 4 psychiatrists (2 positions were vacant in mid-1974), 10 psychologists (4 positions were vacant), 7 psychiatric nurses (1 position was vacant), 8.5 psychiatric social workers (1.5 positions were vacant in mid-1974), an occupational therapist, and a recreational therapist. Overall, only three-fourths of the authorized professional positions were filled in mid-1974. The professionals were assisted by numerous paraprofessionals, including 6 psychiatric LPNs, 44 mental health technicians, an occupational therapy technician, and a recreational therapy technician.⁴

The Las Vegas MHC outpatient program had an average monthly census of 1068 people in FY 1974, of whom about half were primarily receiving psychotherapy and half were primarily receiving chemotherapy. Of those in the center's total active registry of clients, over 90 percent were outpatients; the percentage served per month varied from 33 to 42 percent and averaged about 38. There were 13,940 outpatient treatments in FY 1974. New admissions to the outpatient program averaged 151 per month in FY 1974; total new intakes (new admissions plus readmissions) averaged 172. In the first quarter of FY 1975, the average monthly census rose to 1251, and as more professional staff positions were filled the patients primarily receiving psychotherapy rose from about half to 60 percent. New admissions averaged 177 per month in the first quarter of 1975; total new intakes averaged 226.⁴ This outpatient program is responsible for follow-up of patients released from the Nevada Mental Health Institute (NMHI) who are Clark County residents.

The outpatient program at the main Las Vegas MHC facility had 8.5 full-time-equivalent staff members in mid-1974: 1.5 psychiatrists, 4 psychologists, and 3 social workers.

As of the summer of 1974, the outpatient program was experiencing a significant drop-out rate in excess of 33 percent between the time of the intake interview and the next appointment, signaling possible difficulties with the intake process. One possible difficulty is that patients are assigned at intake to whoever has the duty at the moment. Normally, at intake, a patient would be expected to spend at least an

³ Governor Mike O'Callaghan, *The Executive Budget, Fiscal Years 1975-76 and 1976-77*, State of Nevada, Carson City, Nevada, January 20, 1975. Hereinafter cited as *The Executive Budget*.

⁴ *Ibid.*

⁵ *Ibid.*

hour in consultation with a professional to determine who should be treating him or her on an outpatient basis. This is not done; assignment is best characterized as random. It is desirable to have patients assigned to the staff member whose training and treatment methods seem best suited to the client's needs. The "luck of the draw" assignment method employed by the Las Vegas MHC outpatient program not only results in inefficient use of the available variety of staff resources, but also deprives the patient of the therapeutic belief that rationality has determined the choice of his or her therapist. Whatever the reason for the drop-outs, at the least one would expect there to be follow-up procedures for those who do not reappear for outpatient services. Such follow-up was not pursued during the period of our observation.

The Las Vegas MHC also operates a satellite office in the westside area of Las Vegas, to increase accessibility of residents in that area to services. In mid-1974 it was staffed by one Psychologist III (a middle-level position requiring a master's degree), a social worker, 5 mental health technicians, and a public service intern; still unfilled were the only senior professional position at the satellite (for a psychiatrist) and 2 psychiatric nurse positions. The area served has a concentration of black residents, and the satellite office is staffed primarily by blacks. The satellite office eventually will have three units: intake, treatment, and outreach. The treatment unit was still in the "planning stage" at the time of our interviews in mid-1974, although some group therapy was to begin soon. Reportedly, none of the people were receiving individual psychotherapy or chemotherapy at the satellite office. If people were to receive treatment, they somehow had to get to the main Las Vegas MHC facility five miles away; the satellite office usually did not provide transportation to that facility. Problems with the satellite facility included lack of space and lack of a soundproof room for therapy sessions. The activities of the satellite office included consulting with other community agencies, making referrals of clients to other agencies and to the main Las Vegas MHC facility for service, and helping cut juvenile arrests in the neighborhood by assisting in a "community court" where police could send juveniles rather than arrest them. One staffer organized a karate club and another was thinking of starting a Boy Scout troop. Regarding the lack of direct treatment, we note that the staff of the satellite office in mid-1974 really was not fully skilled or trained to provide direct mental health treatment services of the nature of those provided by the outpatient program at the main facility. Also, the office had no senior professional to guide and supervise on a daily basis those staff members who were there.

The average number of patients seen monthly on an emergency basis rose from 23 in FY 1974 to 35 in the first quarter of FY 1975.⁸ Emergency mental health services are available on a 24-hours-a-day basis. On weekdays, they are provided by the outpatient program's professional staff. Nights and weekends, the inpatient staff provides emergency services; senior professionals are on call if needed. If necessary, inpatient services lasting one day or longer can be provided at the same location in Las Vegas.

Day treatment is provided for people who need more intensive treatment or structure than they could receive as outpatients, but who are not so emotionally disturbed as to require inpatient care. The Las Vegas MHC day-treatment program for adults had a half-time senior psychologist position unfilled in mid-1974, but was

⁸ Ibid.

functioning quite well. Clients were well known by the staff, and vice versa. Supervision of the technician staff by a psychiatrist and a social worker was adequate. Follow-up procedures were well developed and most of the clients had jobs and/or received follow-up services at time of discharge from the day-treatment program. The recidivism rate was a low 5 percent. The adolescent residential treatment program at the Las Vegas MHC also accepted up to 16 youth at a time (over age 12 years) for day treatment (see Chap. 10 for a program description). The adolescent program also includes the services of a special education teacher provided by the Clark County School District. As detailed in Chap. 10, the adolescent program was not functioning well at the time of our interviews, probably because both key senior professional staff positions were vacant.

Average daily attendance at the Las Vegas MHC for day treatment rose from 10.2 people in FY 1974 to 16.3 people in the first quarter of FY 1975; average new admissions to this program rose from 8.0 to 10.3 for the same time periods.*

The community consultation and education program at the Las Vegas MHC was staffed at a low level by two people in mid-1974: an "education and public information" specialist and one clerical-secretarial support employee. In FY 1974 this program averaged 72 "units of service" per month (a unit of service can be one consultation with one other agency, for example). As described in the *Staffing Grant Proposal for the Las Vegas Mental Health Center*:

Consultation will serve to provide specific agencies with assistance in maximizing its effectiveness in providing services to individual clients. The effort is a cooperative one with input from the consultant in terms of his unique skills and training. Program consultation will also be provided to aid in program planning and development within an agency seeking such assistance.

Education will provide first for training of personnel in agencies in early identification of mental health problems so as to facilitate early treatment. Secondly, its aim is to increase public awareness of available services, sources, ways of obtaining service, and purpose.

An advocacy program mentioned in the Las Vegas MHC's 1972 proposal for a federal staffing grant* had not been staffed in 1974, but has since been developed as an "Advocacy/Aftercare Program" with the major function of providing follow-up services to former inpatients of the Las Vegas MHC and the NMHI, and generally to monitor and implement continuity of care. The program performs some of the same functions as the Regional Direction Centers we propose in Chap. 4.

HENDERSON MENTAL HEALTH CENTER

The area served by the Henderson Mental Health Center was created to conform to the definition of a "catchment area" in federal guidelines.* Much of the recent

* Ibid.

* L. Miller, *Las Vegas Mental Health Center*, Las Vegas, Nevada, August 30, 1972.

* L. Miller, *Staffing Grant Proposal for Las Vegas Mental Health Center*, Las Vegas MHC, Las Vegas, Nevada, August 30, 1972.

* For a discussion of the problems associated with those guidelines, see Robert Connery et al., *The Politics of Mental Health: Organizing Community Mental Health Care in Metropolitan Areas*, Columbia University Press, New York, 1968. The issue has also been treated at length in Franklin D. Chu and Sharland Trotter, *The Madness Establishment*, Grosman Publishers, New York, 1974, Chap. 8.

population growth in Clark County has been in the Henderson MHC catchment area. In FY 1974, the Henderson MHC was serving a catchment area of about 226,000 people¹⁰ with a staff of 6-1/2 (professionals plus support staff) and an annual budget of \$128,422.¹¹ Though 90 percent of the Henderson MHC services are to residents of the catchment area, it is clearly impossible to serve the entire need. In reality, many of those in need were being served at the Las Vegas MHC or by private mental health providers, or received no services at all. Although the Henderson MHC contains some elements of a community mental health center, it would be a misnomer to call the current Henderson MHC a community mental health center; it is not. Without additional staff it is impossible for the current Henderson MHC to provide a full range of services. In contrast, the Las Vegas MHC with federal assistance has a staff of 110 and its catchment area has a population of 105,000, less than half that of the Henderson MHC. As a result, the great majority (approximately 70 percent) of the services at the Las Vegas MHC are provided to clients who reside in the Henderson MHC's catchment area.¹²

The operations of the Henderson MHC fall short of what one would expect in a mental health center providing a continuum of care. They fall into only three classes: outpatient services to an average monthly client census of about 250 people, half from the Boulder City-Henderson area and half from the Las Vegas area; limited emergency services for walk-in clients or phone calls during the agency's hours of operation; and consultation and educational services to about 25 Clark County social service agencies in FY 1974.¹³ The center averaged about 35 new clients per month in 1974.¹⁴ The total number of people served in FY 1974 was about 570.

A recent addition to the services has been a satellite center in North Las Vegas. The North Las Vegas Counseling Center has a staff of two. After two months of operation, the client load was 29 with nine new clients in January 1976.

Of the clients receiving service at the center in the last six months of 1975, approximately 22 percent were adolescents. Of the adults served, 39 percent came from disrupted families, 20 percent had less than a high school diploma, 24 percent had incomes below \$3000 and 4 percent were aged 60 or above.

When we interviewed in mid-1974, behavior modification was the predominant treatment modality used at the Henderson MHC; the center did not employ a full range of modalities. No physician or psychiatrist was associated with the Henderson MHC at the time of our interviews, even as a consultant.

In the 1975 Nevada legislative session, four new staff additions were approved: a psychiatrist, a psychiatric social worker, and two clerical staff members.¹⁵ As of December 1975, services were provided by persons trained in a wide range of disci-

¹⁰ "Community Mental Health Center, East Clark County, Nevada," draft proposal attached to a letter to J. S. Kakalik, The Rand Corporation, from David Luke, Henderson MHC, Henderson, Nevada, February 5, 1975.

¹¹ *The Executive Budget*, p. 322.

¹² "Community Mental Health Center, East Clark County," p. 44, and a letter from David Luke, Henderson MHC, Henderson, Nevada, to J. S. Kakalik, The Rand Corporation, Santa Monica, California, February 24, 1976.

¹³ *The Executive Budget*, p. 323.

¹⁴ "Community Mental Health Center, East Clark County."

¹⁵ Information provided by H. Clemons, Management Analyst, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, June 20, 1975.

plines. Psychological services were provided by a doctoral level clinical psychologist and a master's level person trained in behavior modification. Psychiatric services, including chemotherapy, were provided by a board-eligible psychiatrist. A master's level social worker and another bachelor's level staff member rounded out the clinical staff. Other staff qualifications included training in nursing and education.¹⁶

In an overall sense, the biggest problem with the Henderson MHC was and still is its very small size in relation to the majority of the Clark County population it is supposed to be serving.

RENO MENTAL HEALTH CENTER

The Reno Mental Health Center in theory is responsible for mental health services for some 140,000 people who live in Washoe County. However, it does not offer a complete range of services and is not a full-fledged community mental health center in the sense that the Las Vegas MHC is, which has a staff nearly five times as large as that of the Reno MHC.

The Reno MHC has an authorized staff level of 23.5 positions, including 1 administrator, 10 other professional positions, 9 mental health technicians, and 3.5 clerical and secretarial positions.¹⁷ Although the staff is insufficient in size to meet service needs and 9.5 new staff members were requested, no new positions were approved during the 1975 legislative session. The FY 1974 budget was \$375,252.¹⁸ The center charges for its services on a sliding scale, with those unable to pay not being charged.

The Reno MHC provides adult outpatient services to Washoe County residents at a small downtown Reno facility (staffed by three professionals in mid-1974), day treatment services to children and adolescents at another facility on the outskirts of Reno (staffed by 3 Reno MHC professionals, the mental health technicians, and 2 teachers paid with federal P.L. 89-313 education funds), and limited preadmission screening and postdischarge outpatient follow-up services to Washoe County residents by a Reno MHC "Transition Unit" at the NMHI (staffed by 2 professionals in mid-1974). The center also had a small "Community Education Consultation Unit," staffed by 2 professionals. By early 1976, as detailed below, significant changes in staffing had occurred by means of reclassification of existing paraprofessional positions as vacancies occurred and by staff reassignments and transfers. No overnight or longer residential services are provided by the Reno MHC.¹⁹

The new Children's Behavioral Services staff provided by the 1975 legislature will work in conjunction with the Reno MHC staff while the new CBS facilities are being constructed.

The Reno MHC active caseload at one point in time in late 1974 included over 650 people, of whom about 150 were children, adolescents, and their families. In FY 1974, 1200 different people applied for services.²⁰ Since the FY 1974 turnover of

¹⁶ Letter from David Luke, Henderson Mental Health Center, Henderson, Nevada, to J. S. Kakalik, The Rand Corporation, Santa Monica, California, February 24, 1976.

¹⁷ *The Executive Budget*, p. 312.

¹⁸ *Ibid.*

¹⁹ Information in this section was provided by R. Keiffer, Clinic Administrator, and by various other staff members of the Reno Mental Health Center, in interviews conducted between April 22 and November 22, 1974, and in a letter from R. Keiffer to J. Kakalik, The Rand Corporation, February 27, 1976.

²⁰ *The Executive Budget*.

patients typically was 60 to 90 a month, the total number of people served annually is on the order of 900.

The Reno MHC Adult Outpatient Unit was staffed by a psychiatrist, a clinical psychologist, and a psychiatric social worker in mid-1974. It served primarily people with urgent needs, in the opinion of the center's administrator, who cited acute hospital-prone and suicidal cases as examples. Those with lesser needs were usually not accepted for service; they accounted for about one-third of those who applied for service. The social worker provided screening and initial intake interviews of applicants for mental health services, as well as therapy for a very few people. The psychiatrist served an active caseload of about 160 clients, the majority of whom were said to be schizophrenic (about three-fourths of the people on his active caseload were primarily receiving chemotherapy). The psychologist had an active caseload of about 33 (all primarily receiving psychotherapy). In mid-1974, no one answered the Reno MHC telephone at times other than 8 A.M. to 5 P.M. on weekdays. At other times, callers were automatically referred by a recorded message to the Nevada Mental Health Institute and to the Suicide Prevention and Crisis Call Center in Reno. The Reno MHC telephone is now answered 24 hours a day, but even emergency services are not provided other than on weekdays from 8 A.M. to 5 P.M. In early 1976, the Adult Unit professional staff consisted of 3 master's level psychiatric social workers, 1 master's level psychologist, 1 Ph.D. level psychologist, and a full time psychiatrist.

The Reno MHC Family Unit consists of an outpatient section, which serves youth and their families, and the Crossroads School, which is a day treatment program for about 25 severely emotionally disturbed children and adolescents who cannot be served adequately by the existing special education program in the Washoe County schools, but who do not need full residential treatment services. Recall that the Washoe County schools offer almost no special educational services for emotionally disturbed children (see Chap. 7); those emotionally disturbed children are not served in the public schools with an appropriately trained teacher. The Reno MHC thus provides outpatient mental health services to students able to function in existing regular or special education programs in a regular school, and provides a special school with mental health services for those who are not. Demand for services from the Family Unit far exceeds the supply; although 60 percent of the applicants in early 1974 were not accepted, there was a waiting list of about 50 accepted applicants in mid-1974. A chemotherapy program serving about 55 children monthly had to be terminated temporarily because of a lack of psychiatric staff time. In July 1974 the Family Unit served about 200 children and 50 parents (the annual total is about 300 children and youth), with a professional staff of 1 psychiatric nurse, 1 social worker, and 3 teachers. Problems with the Family Unit included its small size, the assignment of all outpatient work to only one employee (the psychiatric nurse), the use of 9 relatively unskilled and untrained mental health technicians in the day treatment program, the lack of professional input to the program by psychologists and psychiatrists (at most a total of about a half-day per week was available to the Family Unit from people with those professional backgrounds), the lack of service to children who did not have private transportation to the facility and to children whose parents would not come in for therapy sessions, and operation in an office building that was not really designed to be a service facility. Major staffing changes have occurred during the past year in this adoles-

cent/family unit. As of early 1976, the staff included a full time psychiatrist and a full time Ph.D. clinical psychologist; two master's level psychiatric social worker positions had been authorized.

The Reno Service League operates a Behavioral Treatment Center for 40 pre-school children per week in the same facility used by the Reno MHC Family Unit's day treatment program for older children and adolescents. A psychologist from the Reno MHC consults with the Behavioral Treatment Center and helps train the Service League women who work there.

The Reno MHC Transition Unit at NMHI, with only a psychiatrist and a social worker plus a half-time secretary for staff, was unable to fulfill its assigned responsibilities adequately (see Chap. 10 for details). Screening of people by the Reno MHC before admission to NMHI was rudimentary at best, supplied the NMHI staff only with the name, age, and sex plus a recommendation regarding admission of the applicant, resulted in nonadmission of only about 10 percent of those screened, and duplicated a later NMHI screening that probably would not have passed most of that 10 percent anyway. Reno MHC predischARGE planning and interaction with NMHI patients was minimal; follow-up after discharge was not provided to all Washoe County residents; and 75 percent of those followed up primarily received chemotherapy. In July 1974, the active caseload of the Transition Unit was about 140. The average number of new patients seen by the unit per month was about 30 in early 1974.²¹ In 1975, NMHI's dissatisfaction with the follow-up of released patients by the Reno MHC led to the development of plans for the NMHI to provide its own follow-up for Washoe County residents (see Chap. 10 for a description of Reno MHC Transition Unit operations in 1974 and the NMHI plans for 1975). The Reno MHC Transition Unit was phased out in November 1975 and the staff transferred to the 580 Mill Street office.

The Reno MHC Community Education and Consultation Unit, with a clinical psychologist and a half-time teacher for staff in late 1974, operated a branch office at Lake Tahoe a half-day a week, and regularly visited community agencies such as the police, the parole agency, the child detention center, Head Start programs, and the schools, to provide consultation and to refer potential clients back to the Reno MHC facility for diagnosis and possible treatment. Staff members of the unit conducted in-service training classes of 4 to 16 hours total duration for teachers, school counselors and nurses, police, probation officers, and public health nurses on how to handle behavior problems in youngsters. Press releases also informed potential clients of the center's services.²² Since 1974, this Community Education and Consultation Unit has been phased out and its staff reassigned to strengthen other units of the Reno MHC. The Adult and Adolescent/Family Units now carry the community education and consultation responsibilities.

RURAL CLINICS

Service delivery in sparsely populated rural areas is a nationwide problem of consequence, and delivering mental health services in rural Nevada is no exception. Delivery is difficult even for services needed by the majority of the population, such

²¹ Interview with R. Keiffer, Reno Mental Health Center, Reno, Nevada, April 22, 1974.

²² Interviews with Terry Weyl, Reno MHC, Reno, Nevada, July 3, 1974, and November 22, 1974.

as general medical care.²³ It is far more difficult for specialized services needed by only a small fraction of the rural population, such as those with substantial mental health disorders. The problem is one not only of economics, but of most mental health professionals' preferring to work and live in the larger population centers. The Rural Clinics program is an attempt to overcome those problems and provide mental health services needed in rural areas of Nevada outside of Clark County and Washoe County. Rural citizens living in those two counties outside the Reno and Las Vegas metropolitan areas are supposed to be served by the Henderson, Las Vegas, and Reno MHCs—and they are, if they are willing and able to travel to the centers, which have no outreach services to rural areas.

Before 1972, the Rural Clinics program operated under a different overall concept. That previous concept involved sending a team of well-trained professionals, usually by airplane, to rural areas periodically to provide mental health services. Since about the end of 1972, the modus operandi has been to use several small field offices located throughout the state and permanently staffed by less well-trained personnel.

Operating with an FY 1975 budget of \$443,203,²⁴ the Rural Clinics program has field offices in Carson City, Elko, Ely, Fallon, Hawthorne, and Winnemucca. The average total number of clients seen per month by Rural Clinics personnel in the first nine months of 1974 was 449 (109 in Carson City, 83 in Elko, 30 in Ely, 28 in Fallon, 140 in Hawthorne, and 59 in Winnemucca). With a client turnover of about 15 percent per month (the actual average for the first half of FY 1974), we estimate the program had about 1200 to 1300 clients in 1974 (including some unknown number of repeat clients). Each local office also has responsibility for smaller towns and communities located nearby, e.g., the Elko center is supposed to serve Wells and Owyhee; Winnemucca serves Battle Mountain; Fallon covers Lovelock; and so forth. Services theoretically are also available to state facilities such as the Northern Nevada Children's Home in Carson City and the Nevada Youth Training Center in Elko. It is the stated objective of the administrator of the Rural Clinics program to make the six community programs independent and, in time, autonomous mental health centers.²⁵

In principle, Rural Clinics is serving a rural population of some 94,000 people, of whom about 34,000 are children, spread over rural Nevada's vast 96,000 square miles. Under the best of circumstances, delivering good-quality mental health services to such an area would be a remarkable accomplishment; consequently, we were not surprised to find that the reality in Nevada falls far short of the desirable. Our recital of some of the major problems with the program will suggest ways to improve service delivery.

The first two problems we noted in 1974 were the small number of staff members in the Rural Clinics program, and the relatively low skill-levels of many of those staff

²³ See, for example, U.S. Department of Agriculture, *Health Services in Rural America*, Information Bulletin 382, Washington, D.C., April 1974; "Lack of Medical Care in Rural Nevada Blamed on Economics," *Nevada State Journal*, March 18, 1976; Economic Research Service, U.S. Department of Agriculture, *Rurality, Poverty, and Health: Medical Problems of Rural Areas*, Economic Report No. 172, Washington, D.C., February 1970; and Peter A. Morrison et al., *Review of Federal Programs to Alleviate Rural Deprivation*, The Rand Corporation, R-1661-CF, December 1974.

²⁴ *The Executive Budget*, p. 315.

²⁵ Interview with Roger Glover, Administrator, Rural Clinics program, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, April 23, 1974.

members. In early 1976, the skills of the Rural Clinics staff had been upgraded somewhat by filling previously unfilled professional staff positions, and by "overfilling" some of the mental health technician positions with master's degree level professionals. However, the problem of the small number of staff members remains, and we question whether the low-paid MHT positions can continue to be overfilled by professionals when the job market ceases to be tight.

The program had 24 authorized staff positions in mid-1974: 1 administrator, 1.5 psychiatrists, 4 psychologists, 4.5 psychiatric social workers, 1 psychiatric nurse, 1 child development specialist, 6.5 mental health technicians, and 4.5 clerical and secretarial support staff.²⁶ At the time of our interviews in mid-1974, some professional positions were unfilled; for example, there were no psychiatrists on the staff or acting as consultants to the program. Later in the year, however, a part-time consultant psychiatrist was hired for at least two hours a week. The mid-1974 professional staffing in each of the Rural Clinics offices consisted of a psychologist and a social worker in Carson City; a psychologist in Elko; a half-time psychologist in Ely; a social worker in Fallon; a psychiatric nurse and a social worker in Hawthorne; and a half-time psychiatric nurse in Winnemucca. A child development specialist traveled a circuit to serve each office.²⁷ Thus, of the 12 authorized professional service personnel, a very small number for all of rural Nevada to begin with, 8 were working in the field delivering mental health services. Each office also has one or two "Mental Health Technicians III," who need only a high school education (as noted below, some of these positions were "overfilled" in March 1976). While those technicians' official job requirements²⁸ also specify a certain amount of "paid work experience" and training (300 to 900 hours, depending on the person's education and experience), in practice they receive much less formal training (some state programs provide none at all). In the Rural Clinics program in mid-1974, we were told a training program was being developed but was not yet in operation. In our view, the technicians were responsible for mental health services they were not fully qualified to perform, either by their prior training or the low level of their training by Rural Clinics. And not having a physician affiliated with this staff-starved program more than a few hours a week severely limited the use of chemotherapy to treat certain mental disorders, with the result that people with those disorders usually had to be served by other more staff-consuming therapies, or not served at all.

The program's administrator expressed his hopes of securing the services of physicians in the rural areas to prescribe medication, but at the time of our interviews in 1974 such services were provided only on an ad hoc basis and by nonpsychiatrists.

The 1975 session of the Nevada Legislature did little to resolve the staff problem; it authorized only 4.5 new staff positions for the Rural Clinics program: 3.5 clerks and typists plus one master's-degree-level psychologist.²⁹

By early 1976, with the filling of previously unfilled staff positions and by limited

²⁶ The Executive Budget.

²⁷ Interview with Roger Glover.

²⁸ See Chap. 10 for the detailed mental health technician job requirements, which were provided by O. Wahrenbrock, Department of Human Resources, Carson City, Nevada, May 13, 1974.

²⁹ Information provided by H. Clemons, Management Analyst, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, June 20, 1975.

hiring made possible by five grants, the Rural Clinics staff had been upgraded somewhat. However, the Clinical Director of the program, Roger Glover, acknowledged in a February 27, 1976 letter to Rand that "there is no doubt that the Rural Clinics program has inadequate numbers of staff to meet the needs of the communities served." The Rural Clinics program in early 1976 employed two psychiatrists, one-half time each, who provided consultation services to each Rural Clinics center on a biweekly basis. In early 1976 the clinical staffing at each center was: Carson, one psychologist, one person with a master's degree in counseling and guidance, and one psychiatric social worker; Elko, one Ph.D. psychologist and one psychiatric social worker; Ely, two master's level psychologists and one substance abuse counselor; Fallon, one master's level psychologist and one person with a master's degree in counseling and guidance; Hawthorne, one psychiatric nurse and one psychiatric social worker; Winnemucca, one master's level psychologist and one substance abuse counselor; and Yerington, one bachelor's level social worker and one master's level psychologist. The six filled mental health technician positions had been effectively upgraded by "overfilling" three of the positions with master's degree level professionals (one each of the counseling and guidance, social worker, and psychologist staff members noted above are actually mental health technicians). The administrator of the Rural Clinic program in March 1976 indicated he had been able to "overfill" these MHT positions because the job market was tight and better people were willing to work for a lower MHT salary; we question what will happen when the job market ceases to be so tight. The other three MHT positions in March 1976 were filled by people with: 1½ years of college education; a B.A., and two half-time predoctoral students.

Direct services such as individual, group, family, premarital, and marital counseling are provided by Rural Clinics staff; some parent effectiveness training is offered; some parents are being assisted to develop a cooperative preschool; some work is being done to curb child abuse; many young children are screened for mental retardation; indirect services such as mental health consultation and behavior modification training to teachers, clergy, and police are also provided.²⁰ In our view, the Rural Clinics program is trying to provide too many different services with too few people.

According to the Rural Clinics *Program Description*, "Rural Clinics' philosophy has never been to provide all of the direct services a community may require, but to strengthen the community's natural service systems by offering consultation, training, and education..." About half the staff time is spent on direct mental health services.²¹

The assessment of the Rural Clinics' administrator was that his mid-1974 staff typically could handle neuroses but not psychoses.²² By his own admission, that is, the program could not furnish adequate outpatient treatment, or adequate outpatient follow-up to inpatient treatment at NMHI, to those rural Nevadans who needed it most sorely. In February 1976, however, the same administrator indicated that "the upgrading of the Rural Clinics professional staff, as indicated earlier, has made

²⁰ Interview with Roger Glover; interview with B. Bilbrey, Rural Clinics program, Elko, Nevada, May 10, 1974.

²¹ *Nevada's Rural Clinics: Program Description*, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, 1974.

it possible to provide services to increasing numbers of people experiencing 'severe mental disorders' in the local community."

The NMHI serves some rural people on an inpatient basis (see Chap. 10), but the Rural Clinics program is responsible for outpatient services to help prevent the need for residential services at the Institute, and for follow-up after treatment at the Institute. However, for Nevadans released from the NMHI to rural areas, there is often no meaningful transition or follow-up by the public mental health service system. In the past, the Rural Clinics mental health program staff used to meet with all Institute patients from rural areas prior to discharge; in 1974, they reportedly saw almost none. Even if they had regularly performed follow-up, the use of certain treatment modalities, such as chemotherapy, would have been restricted because the Rural Clinics program had only a part-time psychiatrist at the time of our interviews in 1974. Because the program also did not have enough skilled clinical psychologists, it is doubtful that the existing staff could have provided effective follow-up mental health services for all rural Nevadans released from the Institute.

The NMHI, in turn, seemingly did not facilitate follow-up in 1974. Cooperation between the Institute and the Rural Clinics program existed on paper, but joint prerelease planning for individual patients seldom occurred; reportedly, the Institute generally did not notify the Rural Clinics program of a person's release until several days afterward. Allegedly, rural residents sometimes entered and left the Institute without the Rural Clinics program's knowledge. When notification was received from the Institute, it was said to consist of the released person's name and county of residence only, with no specific address or mental health information.²²

In a February 26, 1976 letter to Rand, the Administrator of the Rural Clinics program indicated: "The problems of provision of adequate services to rural Nevadans requiring inpatient services continue. One problem was that oftentimes people move into and out of the Institute without the awareness on the part of the Rural Clinics Staff. . . . Inpatient services have been established on a limited basis in three communities in conjunction with local general hospitals through activities of consulting psychiatrists. These services are minimal, but functional. Additional psychiatric services are needed and would allow more intensive follow through."

Rural Clinics service was not sufficient for people living in state facilities in rural areas who needed mental health services. For example, the Nevada Youth Training Center in Elko for adjudicated delinquent males reported having received no services from the Rural Clinics program (in mid-1974) although services had been requested.²⁴ The state-run Northern Nevada Children's Home in Carson City does not have the budget, staff, or service program to provide mental health treatment to residents who need it. At one time, the Carson City Rural Clinics office provided a master's-level psychologist 1½ to 2 days a week. From a waiting list of children, he individually counseled those he had time to see. Since mid-1974, however, because of increased community demand for services, the Carson City Rural Clinics office has no longer provided that service.²⁵

²² Interview with Roger Glover.

²³ Ibid.

²⁴ Interview with C. Stewart, Superintendent, Nevada Youth Training Center, Elko, Nevada, April 1974.

²⁵ Interview with J. Abarastgiri, Superintendent, Northern Nevada Children's Home, Carson City, Nevada, May 9, 1974.

The basic, overriding problem with the Rural Clinics mental health program is that too few people are trying to accomplish far more than their meager numbers would allow under even ideal conditions. It is an excellent example of a small embryonic program with admirable goals that exists mainly on paper as far as many rural Nevadans with mental health disorders are concerned, especially those with the more severe disorders.

CHILDREN'S BEHAVIORAL SERVICES

The Children's Behavioral Services (CBS) program in Las Vegas, operated by the Nevada Division of Mental Hygiene and Mental Retardation, is intended to serve only Clark County children under 13 years of age who need mental health services.⁶⁶ The 1975 session of the Nevada Legislature approved a CBS program for Washoe County patterned after the Clark County program. No comparable program exists for children and youth of any age in rural Nevada counties. For youth aged 13 years and over in Clark County, the Las Vegas MHC provides a range of both residential and nonresidential services. In Reno, Washoe County youth over age 12 presently receive only nonresidential service at the Reno MHC. Even with the new CBS program, then, gaps still prevail in the mental health service system for Nevada children and youth.

The CBS program, according to one descriptive brochure, includes "treatment, education, prevention and research. The goals of the program are to eliminate current difficulties and to prevent the development of future problems."⁶⁷ Positive behavior modification is the treatment modality predominantly employed; as the brochure describes it:

Although we often classify children's difficulties as mental, emotional, social, or behavioral, it is always what the child does (his/her behavior) that causes our concern. In this sense, the problems are almost always behavioral. For this reason, our services are based on the science of human behavior. This science informs us that most of the things children do can be changed by changing the consequences for what they do. Positive consequences for a behavior make that behavior more likely to occur again. On the other hand, negative consequences make a behavior less likely to occur again. Treatment by Children's Behavioral Services is based on the law of positive consequences for desired behavior. In treatment, the children learn to increase doing what they should. In the process, these desired behaviors substitute for the undesired behaviors which decrease or cease altogether.⁶⁸

The 1975 session of the Nevada Legislature approved \$1,450,800 for the construction of a CBS Northern Nevada Emotionally Disturbed Children's Facility in

⁶⁶ Unless otherwise indicated, information in this section was provided in CBS interviews in Las Vegas, Nevada, with J. Burnett, Clinic Administrator, March 6, July 10, and October 25, 1974; C. Hahn, H. Platt, D. Johnson, and B. Salisbury, August 5, 1974; and S. Kruger, October 24, 1974; CBS, Las Vegas, Nevada; in an interview with C. McKee, Chief of Psychology and Social Work Services and project manager for the MOD Center, Clark County School District, Las Vegas, Nevada, October 24, 1974; and in a letter from J. Burnett, CBS, Las Vegas, Nevada to J. Kakalik, The Rand Corporation, Santa Monica, California, February 27, 1976.

⁶⁷ Clark County Children's Behavioral Services, *Children's Behavioral Services*, descriptive brochure, Las Vegas, Nevada, September 1, 1973.

⁶⁸ Ibid.

Reno. It will be identical to that already under construction for emotionally disturbed children in Las Vegas. It includes residential units for short-term intensive inpatient treatment of a maximum of 16 highly mentally disturbed youth, plus a classroom and outpatient service building.³⁹ However, for programmatic reasons and because of financial limitations, the Las Vegas CBS program currently has a full-time residential capacity of only 12 children and 1 family in treatment. Both parents and children will be involved in services, which in Reno will include family counseling, group therapy for parents and children, classes for parents in effective management techniques, individual therapy for children, and an evaluation service. The evaluation service will include a medical and a behavioral assessment of the child and an evaluation of the strengths in his or her social environment. The levels of services to be offered include relatively short-term residential intensive inpatient service, transitional residential placement with specially trained professional parents outside the facility, conventional foster home care services during the full day, and outpatient services. Services as they existed in February 1976 at the CBS program in Las Vegas are described below. Residential intensive services, day care, and outpatient services at each facility are expected to reach about 40, 74, and 500 emotionally disturbed children per year, respectively.⁴⁰ The active caseload in the Clark County program in mid-1974 was approximately 250 children and their families receiving outpatient service, and 20 receiving day-treatment in a special class.⁴¹ About 600 children received services from the Clark County CBS program in FY 1974.

Regarding the need for CBS services, we conservatively estimated in Chap. 3 that at least 2 percent of Nevada's children have emotional disturbances of sufficient severity to require substantial special services in any given year. Since there are about 195,000 children and youth aged 0 to 18 in Nevada, this means at least about 4000 need substantial services for emotional disturbances. About 2500 children are 0 to 12 years old. In February 1974, a Nevada Division of Mental Hygiene and Mental Retardation survey of Washoe County and surrounding northern Nevada agencies asked how many children aged 0 to 12 they knew of who were emotionally disturbed. The agencies reported 57 very severely emotionally disturbed, 147 severely emotionally disturbed, and 1461 moderately disturbed.⁴² These results exceed the 2-percent figure we use in this report, but our figure is a conservative minimum estimate.

The Clark County CBS program began operation in FY 1974 with a budget of \$168,000. In FY 1975 its operating budget was about \$438,000, a new facility was

³⁹ *The Executive Budget*, and February 27, 1976 letter to The Rand Corporation from J. Burnett, CBS, Las Vegas, Nevada.

⁴⁰ Nevada Division of Mental Hygiene and Mental Retardation, *Children's Behavioral Services—Washoe County*, Department of Human Resources, Reno, Nevada, February 1975.

⁴¹ Interviews with J. Burnett and B. Salisbury, CBS, Las Vegas, Nevada, March 6 and August 5, 1974, respectively.

⁴² Division of Mental Hygiene and Mental Retardation, *A Proposed Treatment Program for Emotionally Disturbed Children in Washoe County*, Nevada Department of Human Resources, Reno, Nevada, August 1974. The definitions used in that report are: Very Severely Emotionally Disturbed (typically called psychotic, autistic, etc. Examples of very severely disturbed behavior might include: bizarre thinking; hallucinations, non-speaking and non-communicative, severe self-mutilation, etc.); Severely Emotionally Disturbed (examples of severely disturbed behavior: two or more problems of a serious nature such as extreme and unreasoning fears, unusual sexual preoccupations or perversions, cruelty to animals or children, severe shyness and social withdrawal, habitual fire-setting, etc.); Moderately Disturbed (examples of moderately disturbed behavior: habitual lying, truancy, theft, emotional dependency, lack of friendships, continual feelings of worthlessness and unhappiness, etc.).

under construction,⁴³ and the program had an authorized staff of 17. The staff included 1 administrator, 1 receptionist, 1 account clerk, 2 secretaries, 1 business manager, 1 supervisor of volunteer services, 4 mental health technicians and 5 professionals (a psychologist, 2 social workers, and 2 teachers).

The CBS facility in Washoe County not yet being complete, the 1975 session of the legislature approved only about \$47,000 in salaries for four staff positions to start up the new program in FY 1976.

With the CBS facility in Clark County near completion, the 1975 legislature approved \$161,000 a year in salaries for new staff positions for it, over and above the 17 FY 1974 staff positions: a pediatrician or psychiatrist, 2 child development specialists, 3 sets of "professional parents," one relief parent, and a custodial worker. Seven additional positions were authorized, conditional on receipt of sufficient federal Social Services funds which have now been received.⁴⁴ We have two comments about the Clark County staffing. First, a physician with specialty training in psychiatry should be hired since some of the children to be served undoubtedly will need psychiatric services (see the discussion earlier in this chapter on the desirability of offering an expanded range of treatment modalities to meet the range of children's needs). CBS might be fortunate enough to hire a physician with specialty training in both psychiatry and pediatrics; if not, then the program would also need to provide for pediatric services on at least a part-time consultant basis. Second, the staff conditionally authorized can be put to effective use—services would have suffered markedly if the federal funds had not been there to hire them.

Next, this section describes the two major elements of the CBS programs as they existed in 1974 in Clark County: the MOD Center program and the Community Learning Consultants program.

The Model Orthogenic Development (MOD) Center program in 1974 was a day-treatment program confined to about 20 clients at any one time on the campus of the Sunrise Acres Elementary School. Its treatment modality was based on behavior modification. The program was designed for disruptive elementary schoolchildren with "social, behavioral, or emotional problems" who had been expelled or would soon have been expelled from the regular school program.⁴⁵ It was jointly operated by CBS and the Clark County School District in 1974, but is now operated by the school district with consultative assistance from CBS. A "contract" was written whereby the principal of the child's original school agreed to take the child back when the frequency of offensive behavior was lowered to some acceptable level. The MOD Center staff also consulted with regular classroom teachers on how to handle disruptive children when they returned. Mandatory attendance sessions with the parents also were held by the MOD Center teacher an average of twice per month to help them learn to work with the child at home in modifying her or his behavior.

The small size of the MOD program was determined by available funds and staff. According to the CBS administrator, the program would be swamped if it undertook direct consultation with all the school district's problem children.⁴⁶ The MOD Cen-

⁴³ *The Executive Budget*, p. 325.

⁴⁴ Information provided by H. Clemons, Management Analyst, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, June 20, 1975.

⁴⁵ Children's Behavioral Services, MOD Center, undated descriptive brochure (used in 1974).

⁴⁶ Interview with Joe Burnett, CBS, Las Vegas, Nevada, March 6, 1974.

ter teacher said he received two or three referrals each week, virtually all of whom needed the program but could not be admitted because of its small size.

The MOD Center was officially staffed by a psychologist, a social worker, two teachers, and a mental health technician, but the building housing the MOD program did not have facilities for support personnel offices.⁴⁷ On the day we visited the center, the teaching staff were present plus an unpaid observer from the university who was counting the number of times different behaviors occurred. A psychologist had not been hired, and the work-study observers from the University of Nevada at Las Vegas (UNLV), according to the teacher, were not qualified to do more than observe and count behaviors. One UNLV special education professor consulted with the teacher and tested the children for six hours a week. In addition, the school district psychologist, social worker, and school principal and nurse could be consulted. The MOD center was also serviced by the CBS pediatrician for physical exams.

The teacher said he does academic work with the children as well as behavior modification. Otherwise, he believes the children would slip so far behind academically that their behavior would regress when they returned to their regular schools.

Of the 35 children who received service from the Sunrise Acres MOD program during the 1974-75 school year, only 35 percent returned for the start of the 75-76 school year. Most of the children who returned had attended in the 1974-75 school year for an average of only 3½ months. Eleven of the children returned to regular class or were referred for phasing into regular class. Seven children met criteria in the cooperative programs that had been established in other Clark County Schools and were phased into appropriate classroom settings and 5 of the children moved out of the Clark County School District.

According to the teacher, great unmet needs prevailed in Henderson, Boulder City, and Las Vegas. The most severely emotionally disturbed children were not admitted to the center, and similar services did not exist in southern Nevada's rural areas.

CBS called its 1974 behavior-modification-based outpatient work with children and their parents the Community Learning Consultants program. "This program educates families in effective child management and assists families in evaluating their children's behavioral problems, treating the problems, and ensuring that once treated, the problems do not return."⁴⁸ The program primarily worked directly with the parents, in groups and individually. Parent training groups typically met once a week for eight weeks. In October 1974, about 250 families were involved in this program, up from 150 as recently as March 1974. Mildly and moderately disturbed children were served, but the CBS director said in 1974 that very few severely disturbed children were served. Information provided by the CBS director in February 1976 indicates that more severely disturbed children are now being served, however.

The CBS staff recently analyzed 211 active cases (those currently receiving continuing services from CBS clinical staff) to ascertain the degree of emotional disturbance in CBS clients. According to a February 27, 1976 letter to Rand from the CBS Director, the categories they used were:

- "Very Severely Emotionally Disturbed (typically called psychotic, autistic,

⁴⁷ MOD Center.

⁴⁸ CBS, *Children's Behavioral Services*.

etc). Such behavior might include: bizarre thinking, hallucinations, non-speaking and noncommunication, severe self mutilation, and the like."

- "Severely Emotionally Disturbed. Such children may have two or more problems of a serious nature, such as extreme or unreasoning fears, unusual sexual preoccupations or perversions, cruelty to animals or children, severe shyness and social withdrawal, habitual firesetting, etc."
- "Moderately Disturbed. Such behavior may be marked by habitual lying, truancy, theft, emotional dependency, lack of friendships, continual feelings of worthlessness and unhappiness, etc."
- "Mildly Disturbed. Such children may have non-compliant, non-attentive or back-talk behaviors. This service is basically preventive in nature."

The CBS staff, using the above definitions, reported in February 1976 that only 6 percent of the clients were very severely disturbed, while 26 percent were severely disturbed, 41 percent were moderately disturbed, and 26 percent were mildly disturbed.

Regarding program effectiveness, the CBS Director reports that "in a random survey 100 percent of the parents responding to the survey indicated that they were more able to cope with their children after completing the agency's parent consultation program."⁴⁹ Thus, this program, which uses behavior modification techniques almost exclusively in treating children's mental health problems, appears to be producing some behavior improvement. We know from the available data presented later in this section that parents report better behavior from their children, but we do not know from the data how emotionally disturbed the children are—i.e., we do not know the children's levels of psychological functioning.

We queried staff members on diagnostic evaluation procedures, treatment modalities, and the types of clients served. We learned that in 1974 behavior modification techniques were used almost exclusively (even though different treatment approaches may be appropriate for, say, a severely depressed child who has attempted suicide). It also appeared that a substantial portion of the CBS outpatient caseload consisted of children who were only mildly emotionally disturbed; but given the apparent lack of in-depth contact with and diagnosis of the children's problems this CBS program had in 1974, neither we nor the CBS staff could tell how many children were only mildly disturbed. The question is: given limited staff, who should be served? There is no doubt that the outpatient portion of the FY 1974 Clark County CBS program lacked in-depth intake screening and diagnosis of the children's problems in 1974. One staff member said he had had cases in which he had never seen the child during the entire course of treatment. He was proud that he was treating the child by teaching the parents, and said that typical procedure in the program was to try to make at least one home visit to see the child during the program; he added, however, that "not everyone does this all of the time." In the absence of initial contact with the identified patient, it is very difficult to diagnose the disorder, and hence ascertain the most appropriate intervention strategy. Lack of subsequent follow-up contact makes it hard to learn of any undesired consequences of the treatment (e.g., "symptom substitution" or worse). For example, a child may respond

⁴⁹ Attachment to letter from J. Burnett, CBS Director, Las Vegas, Nevada, to J. Kakalik, The Rand Corporation, February 27, 1976, providing a correction to a letter from J. Burnett to J. Kakalik dated March 12, 1974.

to behavior modification techniques by abandoning objectionable behavior, only to become very depressed. In such a case the CBS program would rate the treatment as "successful," although the mental health problem may not have been resolved at all—only submerged in depression. The point here is not to suggest that behavioral treatment has little value, or that it is frequently accompanied by symptom substitution; rather, it is that the complex outpatient mental health needs of children require a thorough and systematic pre- and post-treatment evaluation in order to ensure the potentially beneficial effects of a behavior treatment program as one component of a comprehensive range of services. (See the "Range of Treatment Modalities" section later in this chapter.)

The Las Vegas CBS director, Joe Burnett, provided significant new information on how the program is currently functioning with a February 27, 1976 letter to Rand.

In the area of "clinical assessment," the material Burnett provided describes a situation that appears markedly different from what we observed in practice in 1974. He indicates:

When a child is referred to Children's Behavioral Services, an effort is made to accumulate complete information in order to assess the physical, psychosocial and intellectual-academic functioning of the child. The components of this assessment are:

Physical. The intake procedure at Children's Behavioral Services includes a comprehensive physical workup. . . .

In an effort to broaden health care services, various working arrangements have been developed with outside individuals, agencies or health care facilities. CBS currently has working arrangements for optometric services, dermatological services, specialty laboratory services, audiological services and consultative developmental diagnostic services. The agency has a written working agreement with the Henderson Mental Health Center for psychiatric consultation and is developing a similar agreement with Las Vegas Mental Health Center. . . .

Psychosocial. In assessing the history and current circumstances of a child, several components are investigated. Permission is obtained from the parents or guardian to allow records from other professionals and agencies to be procured. These records include documentation from the school district, juvenile court, welfare, family physician and any other resources utilized by the child. . . .

Intellectual-Academic. CBS staff includes educational and psychological specialists who perform testing services which provide a measure of the child's intellectual functioning and academic performance.

In the areas of "Individual and Group Parent Consultation, Home Visits, and Families in Residence," the material Burnett provided states:

In the individual, and group, parent consultation programs, clinical staff teach parents skills in improving the interaction between family members. The objective of these improved interactional skills is to support the child's behavioral adjustment. . . .

A clinician may conduct some or all sessions in the client's home. Home based services assist in making assessment, developing objectives or implementing portions of the treatment program. Home visits may be made when

the family has a serious transportation problem or when the problems are such that they can be more adequately dealt with in the home setting. In the latter case, the families in residence program may also be considered.

Families in residence may be appropriate when the child's behavior is severely and dangerously disruptive or in other situations in which an intensive degree of closely supervised treatment is necessary. For example in cases of severe child abuse [sic] . . .

This situation, in which the parents live in an apartment complex that is part of the CBS facility, can be used during acute periods, allowing the clinician to observe problems first hand and provide the family with ongoing consultation and support designed to remediate the situation.

The apartment facility is also used in conjunction with the residential program so that the teaching parents can spend weekends working more intensively with the parents of children in the residential program.

Although CBS programs are described as separate service areas, the more frequent situation is one in which the child and his family are receiving more than one type of service. With the exception of parent education (to be discussed later), all children receiving services are seen by members of the clinical staff. . . .

Data reported in the Fall 1974/Winter 1975 of People Magazine reports a parent evaluation of treatment programs as follows:

1. One hundred percent of the parents completing consultation programs said they were more able to cope with their child.
2. Seventy-five percent of the parents indicated that all treatment goals were reached and the remaining 25% believed partial success had been obtained.
3. Ninety-six percent of the behaviors disapproved by parents had shown some improvement following treatment.
4. Eighty-two percent of the parents said they felt they could handle new behavior problems arising in the home environment.
5. Eighty percent of the parents surveyed said they had recommended CBS to other families.

In the area of "child counseling," the material Burnett provided states:

As with the parent consultation program, child counseling procedures include individualized treatment objectives, measurements of effectiveness and treatment plan revisions as needed. Child counseling services are provided on an individual basis or in a group setting depending on the child's specific behavior or developmental problem. . . .

Some of the techniques used by staff members include assertive training, relaxation training/anxiety management, systematic desensitization, role playing, behavioral rehearsal, continency contracting, problem solving and discrimination training. . . .

Child counseling services are frequently provided along with other available services based on assessments of the individual case. And, child counseling services may include both individual and group counseling. . . .

In the area of "social skills groups," the material Burnett provided states:

In cases where a group setting appears to offer the child a more viable method for learning and practicing new appropriate skills, the child is enrolled in one of the social skills groups.

The program for relationship development (Social Skills Groups) is directed toward children between the ages of 6 and 12 who are experiencing difficulty getting along with others. . . .

The groups meet for approximately one hour each week for ten weeks. The maximum group size is four children and two adult leaders. . . .

In the area of the "Developmental Center and Learning Center Preschools," the material Burnett provided in February 1976 states:

The Children's Behavioral Services Developmental Center and Learning Center preschools are model programs for dealing with preschool children lagging in behavioral and learning development. . . .

The Developmental Center is co-sponsored by the Nevada Division of Welfare, Children's Behavioral Services and the University of Nevada, Las Vegas, College of Education, and Department of Special Education. The children are referred through the Division of Welfare, the C.B.S. staff provides the programming, and the University provides the facilities.

The Learning Center is sponsored solely by Children's Behavioral Services. The children in the Learning Center are referred by their parents for similar kinds of problems. . . .

The children, ages 3 to 5, are referred to these Preschool Programs on the basis of learning and behavioral developmental lags. The enrollment is limited to ten children in each session. . . .

With respect to the "Model Orthogenic Development Center," there are now two MOD Centers in Las Vegas: the Center at the Sunrise Acres which existed in 1974 and was described above, and a new MOD Center at the CBS facilities. The material Burnett provided states:

The Model Orthogenic Development classrooms at Children's Behavioral Services opened October 20, 1975. There are two MOD classrooms which are staffed by teachers with training in special education. These classrooms are jointly sponsored by Children's Behavioral Services and the Clark County School District.

There have been seventeen children enrolled in the classrooms. Six of those children have successfully completed the MOD Program and have been transitioned to the regular classroom in their respective home schools.

All twelve of the children in the OASIS Residential Treatment Program [described below] attend the MOD classroom until the social and academic success of each child indicates that he is ready to be transitioned to a regular classroom. In addition, four community children who are not residents of OASIS attend MOD. Children whose behavior has made it impossible for them to function in a regular classroom are referred to the program. A child who exhibits the following behaviors may be referred:

1. Excessive fighting
2. Aggressive behavior to adults
3. Consistent refusal to participate in the classroom work
4. Stealing

5. Destruction of property
6. Disruption of classroom and school activities

With respect to the "OASIS Residential Treatment Program," the material Burnett provided states:

The OASIS Residential Treatment Program is based on a group home model developed and researched by the Achievement Place Research Project at the University of Kansas.

Achievement Place is a community based, family style, residential treatment program for delinquent youth. . . .

The OASIS Residential Treatment Program opened for residential placement October 1, 1975. Since opening, fourteen children have been admitted to the program. One of the children has graduated and is now doing very well with foster parents. A second child is on the homeward bound system and is spending a majority of his time in his natural home. . . .

Children in need of residential treatment for behavioral or emotional problems may be referred to the OASIS Residential Treatment Program of Children's Behavioral Services by the family of the child, the school, the Division of Welfare, or other concerned agencies and individuals. . . .

Children who meet the following criteria are acceptable referrals for placement in the OASIS Residential Treatment Program.

1. They have not yet entered the 7th grade and are under the age of 13.
2. They have families who: (1) will accept them back in their home at the end of the residential treatment period; and (2) will work closely with the residential staff during the treatment period.

The family will normally be expected to be in contact with residential staff a minimum of three times a week. The family's involvement during residential treatment will include parent conferences, observing the child in the residential setting, home visits made by the staff and other indicated training techniques.

During residential treatment the family will be expected to accept the child back in the home for regular visits during which the family and child practice and evaluate the interactional skills they have learned. If a child is referred who has no family, the OASIS staff will work with the Division of Welfare in training a foster family with whom the child can learn.

3. Their behaviors are of such a nature that they would benefit from medium term residential treatment.
4. Their treatment history is represented by one of the following situations:
 - (a) has exhausted all other services provided by Children's Behavioral Services or other community treatment facilities.
 - (b) the child's problems are so serious and/or of such long duration that other community services would not be appropriate.
 - (c) the interactions between the child and his family or community have degenerated to the point that residential placement is required.
5. The Wechsler Intelligence Scale for Children or Binet indicates that their intelligence potential is not sub-normal.

6. Their physical condition does not require specialized care or equipment that the agency is unable to provide.

In the area of the "Parent Education Program and Community Consultation," the material Burnett provided in February 1976 states:

The parent education program is designed to assist prospective parents in maximizing their child rearing skills and minimizing the possible incidence of future problems. This program is offered to pre-adoptive, expectant and potential foster parents. It is also available to parents who are not experiencing problems as well as those whose children are currently living outside the home. Basic principles of behavior management are taught along with the educational components of a positive environment. The parent's role in the development of desirable behavior is stressed and specific behavioral techniques are taught. Training is usually conducted in group settings in which actual problems are presented for the parents to "solve" with assisted practice.

Agency staff are available as lecturers for educational institutions, civic groups, and community organizations for the purpose of giving information on clinical concerns, and child development and management techniques. Also, schools, social agencies, and court systems in providing services to children may call on CBS for workshops and/or case consultation.

MENTAL HEALTH SERVICE PROGRAMS IN EDUCATION AGENCIES

County School Districts

Special education services for seriously emotionally disturbed children were discussed in Chap. 7. In summary, a total of only about 100 emotionally disturbed children are identified as receiving special education services in Churchill, Clark, and Washoe Counties combined. No seriously emotionally disturbed child is known to be receiving any appropriate special education services in any of the other counties in Nevada. In relation to the minimum number of Nevada children and youth needing special education, only about 4 percent of the seriously emotionally disturbed children are identified and served in programs designed to meet their needs. Some unknown additional number of those children are grouped with "educationally handicapped" children in special education programs that may or may not be appropriate to their needs.

Nevada school psychologists presently function primarily as psychometricians, doing testing of children rather than offering therapeutic treatment of children's mental health disorders. Most of the psychologists would need some retraining to enable them to serve seriously emotionally disturbed children satisfactorily.

In short, mental health services are only slightly developed in the schools, and reach few seriously emotionally disturbed children.

University of Nevada

Some direct mental health services are provided through the University of Nevada at both the Las Vegas and Reno campuses. The FY 1974 Student Services

budget for the University included \$41,440 for a staff of 2.88 full-time-equivalent employees in Reno, and \$55,648 for a staff of 4.10 full-time-equivalent employees in Las Vegas.⁵⁰ At the Reno campus, ten doctoral students in psychology assist the regular staff.⁵¹ Any registered student is eligible for therapy for any emotional or personal problem. Therapy programs include individual therapy, group therapy, awareness groups, marriage counseling, and consciousness raising groups. The Las Vegas campus served about 350 people in FY 1974,⁵² but clearly not all of those served had serious mental health disorders. We did not obtain data on the number served in Reno, although it was probably at least as many per staff member as in Las Vegas since graduate students assist the staff in Reno; i.e., the total was at least 250.

PRIVATE NONRESIDENTIAL MENTAL HEALTH SERVICES

Psychiatrists and psychologists in private practice are an important part of the mental health service system. Private residential mental health services are discussed in Chap. 10. Here we are concerned with estimating the amount of private nonresidential mental health services available in Nevada. Their existence is important but is by no means sufficient to meet all of the state's needs.

The Nevada Welfare Division periodically prepares a list of practicing psychiatrists and psychologists approved for Medicaid payments. The August 1974 list contained 26 psychiatrists and 11 psychologists. Of the psychiatrists, 17 practiced in the Reno area (4 primarily at the NMHI, 2 at the Reno MHC, 2 at the University of Nevada, and 9 primarily practicing privately). The Las Vegas area had 9 psychiatrists (1 primarily practicing at the Las Vegas MHC, 1 at Southern Nevada Memorial Hospital, and 7 primarily practicing privately). Of the psychologists, 7 practiced in the Reno area (1 primarily at the Reno MHC and 6 primarily practicing privately), and 4 practiced in the Las Vegas area (all primarily in private practice). In mid-1974 no psychiatrists lived and practiced in any rural Nevada county, although one Utah psychiatrist flew to Elko to practice an average of about one day a week. Since mid-1974, the number of psychiatrists has grown. The Las Vegas MHC has added 2, for example, and in September 1975 the Nevada State Board of Medical Examiners approved 9 psychiatrists for licensure.⁵³

The Nevada Psychological Association Membership Directory (revised September 1973) listed 42 full members and 15 associate members, but not all are delivering mental health services; many are working as psychometrists in schools. In mid-1974, there were 32 certified psychologists in Nevada, of whom 11 were in private mental health practice.⁵⁴

The geographic distribution of these professionals is lopsided in relation to need. Almost twice as many practice in the Reno area as in the Las Vegas area, although the population of the Las Vegas area is about twice as large. And the rural areas,

⁵⁰ The Executive Budget.

⁵¹ Interview with Dr. J. Mihawa, University of Nevada, Reno, Nevada, April 23, 1974.

⁵² Clark County Area-wide Comprehensive Health Planning Advisory Council, Clark County Plan for Health, Las Vegas, Nevada, December 1974.

⁵³ "55 Physicians Licensed by State Medical Board," *Las Vegas Review Journal*, September 11, 1975.

⁵⁴ Interview with R. Whitemore, Sparks, Nevada, September 18, 1974.

containing about 20 percent of the Nevada population, have no psychiatrists and psychologists at all in private practice, according to the Medicaid-approved list.

In 1973, there was a national average of one psychiatrist for every 10,200 people.²² If that average prevailed in Nevada, the state would have had 57 psychiatrists in 1974 instead of the actual 26; and the prevalence of mental health disorders in Nevada is probably greater than the national average. The 1974 *Clark County Plan for Health*²³ estimated a need for a total of 33 practicing psychiatrists in Clark County, using a recommended ratio of one psychiatrist per 10,000 general population. By that standard, then, the state as a whole in 1974 had less than half the national average and the recommended ratio of psychiatrists; Washoe County had more than the national average and recommended ratio; Clark County had about one-third of the recommended ratio; and the rural counties had less than one-tenth of the recommended ratio (even after we allocated the NMHI psychiatrists in proportion to the geographic residence of the patients they treated).

Recently, a national survey was conducted of a random sample of psychiatrists who spend 15 or more hours per week in direct patient contact in their private offices.²⁴ The average proved to be 32 patient-visits per week. (The survey did not gather information on private inpatient services, partial hospitalizations, and emergency services.) The survey also estimated a gross income per psychiatrist "in the neighborhood of \$67,000 per year" (based on an average hourly fee of just under \$40) and a net taxable income of about \$47,000. We were unable to get reliable similar information on Nevada's private psychiatrists and psychologists, but, if one assumes the national average of \$67,000 for private practicing psychiatrists, and perhaps \$30,000 for private practicing psychologists, then the two groups together gross about \$1,400,000 per year. That figure does not include fees earned by publicly employed mental health professionals who have part-time private practices, as many of them do in Nevada.

We were unable to obtain data on the total number of people served privately in Nevada in FY 1974, but if we again use the average of 32 patient-visits per week, then there were about an average of 1600 patient-visits per year for each of the 26 primarily private practicing professionals in Nevada, or about 42,000 private outpatient visits. Using the national survey distribution of total number of visits per patient in psychiatric (nonpsychoanalytic) caseloads, we calculate that the national average caseload was about 163 different patients.²⁵ Applying that average to Nevada yields a total of about 4200 different private outpatients in FY 1974.

We caution that these estimates are based on national averages. They may indicate the correct order of magnitude of the expenditures and of people provided

²² J. Marmor et al., *Psychiatrists and Their Patients: A National Study of Private Office Practice*, Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, Washington, D.C., 1975.

²³ Clark County Area-wide Comprehensive Health Planning Council, Las Vegas, Nevada, December 1974.

²⁴ Marmor, *Psychiatrists and Their Patients*.

²⁵ Ibid. p. 23. A methodological point is necessary concerning interpretation of data on p. 23 of Marmor's study. By virtue of the way the patients were sampled in the national survey (the last ten patients seen were sampled), patients who came to the office more often were more likely to be selected than were patients who came less often. Hence the average total number of visits by a patient in the caseload is less than the average total number of visits by a patient in the sample. After mathematically adjusting for differences between the average patient sampled and the average patient in the psychiatrists' caseload, we find that the national average number of visits per patient over the entire course of treatment is approximately 10 for psychiatrists who are not psychoanalysts.

outpatient mental health services privately in Nevada, but the actual numbers are unknown.

SUICIDE PREVENTION AND CRISIS CALL CENTERS

Centers are operational in both Las Vegas and Reno to assist people who are suicide prone or have some other crisis by talking with them on the telephone or referring them to other service personnel.

The Reno Suicide Prevention and Crisis Call Center is a joint operation between the University of Nevada and volunteers.⁸⁸ Financing of about \$7000 per year is provided by United Way. The university provides the building rent-free and provides a semester's training (40 to 50 hours total) for the volunteers who answer the telephones. There are about 75 to 80 nonprofessional volunteers and about 12 professional back-up staff members, e.g., social workers and psychologists, who volunteer their time. In late 1974, with a \$6000 grant from United Way and \$5000 in financial assistance from the nonoperating Washoe Community MHC, the Suicide Prevention and Crisis Call Center was able to hire its first full-time paid professional.⁸⁹ The Suicide Prevention and Crisis Call Center is operated 24 hours a day, but talks to people only on the telephone—no walk-ins. A total of 4589 initial calls were received in 1973. The number of new calls per day was averaging about 20 in late 1974.

As would be expected, calls are rather lengthy and result in referrals to other community agencies. The center tries to call back later to check on the individuals, but does not always succeed. Professionals do not usually answer the phones, but provide back-up. About 10 to 20 percent of the calls are in fact suicide-related; the remainder are concerned with depression, psychosis, problems with lodging and food, and so forth. Only about 10 percent are not related to mental health. As of April 1974 the center offered the only 24-hour service of its type in northern Nevada (the Reno MHC, however, has since begun answering its telephone on a 24-hour basis). Despite these impressive beginnings, problems remain. Other than 8 a.m. to 5 p.m. on weekdays, in-person services from psychologists or psychiatrists are said to be often unavailable in Reno; and general public knowledge about the center and its program is slight (a recent survey indicated that less than 5 percent of those contacted had even heard of the Reno program).⁹¹

At the same address as the center is the Washoe Community Mental Health Center—an extremely misleading name, since the organization has no staff and directly provides no mental health services. The name represents a hope rather than an operating service reality. Expenditures by the Washoe Community MHC in the two years through August 1974 had amounted to \$62,000 of the \$72,000 it had available. Little was accomplished with the funds beyond providing a directory of mental health services in Reno, an information and referral telephone line (answered in late 1974 by the Reno Suicide Prevention and Crisis Call Center), and several workshops. Half the remaining \$10,000 was given to the Crisis Call Center in late 1974. Reno does need a functioning full-fledged community mental health

⁸⁸ Interview with J. Mikawa, Suicide Prevention and Crisis Call Center, Reno, Nevada, April 23, 1974.

⁸⁹ "Call Center Saved," *Nevada State Journal*, Reno, Nevada, November 19, 1974.

⁹¹ Interview with J. Mikawa.

center, but we believe the best way to acquire one is to improve and expand the existing state-operated Reno MHC, not create a new and competing one (see the recommendations section of this chapter).

The Suicide Prevention Center in Las Vegas also provides a 24-hours-a-day telephone service run by volunteers.²² It is a nonprofit organization supported by contributions. An average of six calls are received per day and are answered by about 40 volunteers, who are psychologically screened and provided with training for about six evenings prior to beginning work.

FEDERALLY OPERATED MENTAL HEALTH PROGRAMS IN NEVADA

The two major Nevada populations receiving mental health services directly from federally operated programs are Indians and the military.

Indian Health Service

The approximately 9000 Indians in Nevada in 1970 represented about 1.6 percent of the state's population. Of these, the Intertribal Council of Nevada estimates that about half live on Indian reservations or in colonies (see Table 8.3). In 1975, there were an estimated 10,000 Indians on reservations and in colonies, and perhaps 4000 in urban areas; the increase in numbers was reportedly due to migration into Nevada from other states. Although eligible for the same mental health services available to other Nevada citizens, geographic location of residence, lack of transportation, and cultural differences probably inhibit full use of these services.²³

For the Indians living on reservations and in colonies in Nevada, the United States Public Health Service's Indian Health Service (IHS) provides one Ph.D. psychologist, who is given a travel budget only, plus one mental health technician and one recreational therapist assigned to work at Owyhee. The psychologist does not provide direct counseling services to Indians. Rather, he provides consultation and inservice training workshops to community health representatives and other professional and paraprofessional personnel who work with Indians. There is no federal allocation of funds, other than salary and travel expenses, for providing mental health services. Obviously, these three staff members can provide only a very small amount of mental health services.

The IHS provides two hospitals for Indians: Owyhee (near Elko) and Schurz (near Yerington and Fallon). At Owyhee, a psychiatrist from Reno flies in one-half day twice a month, and typically sees five or six people in four hours. There are no mental health services at Schurz.

Other programs specifically serving mentally handicapped Indians include the Intertribal Council alcohol abuse program described in Chap. 9 of this report, which has offices in nine locations throughout the state, and the Stewart School, described in Chap. 13.

²² "Suicide Center Seeking Phone Service Volunteers," *Las Vegas Review Journal*, May 10, 1974; *idem*, "Volunteers Take Death Calls," October 1, 1974; *idem*, "Potential Suicides Prevented," May 31, 1975; *idem*, "Training Set for Suicide Program," September 9, 1975.

²³ Information obtained from Dr. Dean Hoffman, Mental Health Consultant, Indian Health Service, Sparks, Nevada, 1974, and March 1976.

Table 8.3

INDIAN RESERVATIONS AND COLONIES IN NEVADA, 1970

Reservation or Colony, and Tribe	Tribal Members	Resident Population
Duck Valley (Shoshone)	1200	817
Duckwater (Shoshone)	150	63
Fallon (Paiute-Shoshone)	1200	127
Goshute (Shoshone)	200	109
Fort McDermitt (Paiute-Shoshone)	500	353
Moapa (Paiute)	350	73
Pyramid Lake (Paiute)	900	399
Summit Lake (Paiute)	50	1
South Fork (Shoshone)	102	102
Walker River (Paiute)	1000	375
Yomba (Shoshone)	100	61
Battle Mountain (Shoshone)	59	59
Ely (Shoshone)	150	31
Fallon (Paiute-Shoshone)	1200	61
Las Vegas (Paiute)	94	94
Lovelock (Paiute)	150	136
Elko (Shoshone)	140	140
Carson (Washoe)	129	129
Dresselville (Washoe)	153	153
Winnemucca (Paiute)	30	30
Woodfords (Washoe)	250	250
Yerington, Campbell Ranch (Paiute)	400	250
Reno-Sparks (Washoe-Paiute)	525	499
Total	9032	4312

SOURCE: Intertribal Council of Nevada, 98 Colony Road, Reno, Nevada 89502.

Military

Mental health services are provided to military employees, their dependents, and veterans through Nellis Air Force Base outside Las Vegas, and the Veterans Administration hospital outside Reno.

Nellis Air Force Base has only an outpatient mental health program staffed by 4 people: a psychiatrist or psychologist, a social worker, and 2 mental health technicians.⁴⁴ The base is the primary mental health services location for all military installations in Nevada; military employees needing those services are transferred temporarily to Nellis. If the Nellis program is not appropriate for an active duty employee, the program can transfer the employee out of state to a larger Air Force hospital for inpatient care, or can purchase services from civilian mental health professionals and facilities in Nevada. In 1974, active duty personnel averaged 180 patient-hours per month of outpatient mental health service at Nellis, dependents 70, and retirees 5. In addition, as of November 1974 there were 35 mentally retarded and 11 emotionally disturbed children of military employees receiving services in

⁴⁴ Interview at Nellis Air Force Base, Las Vegas, Nevada, November 1, 1974.

the civilian mental health service system, expenses being paid by the military medical insurance program, CHAMPUS.

The Veterans Administration hospital in Reno has plans for a 24-bed inpatient mental health program and a 12,000 annual outpatient-visit mental health program. A multidisciplinary staff will also provide day treatment, and a night-only treatment program. The staff includes 5 psychologists, 1 social worker and 3 psychiatrists.

MENTAL HEALTH SERVICES FOR MENTALLY RETARDED PEOPLE

Mentally retarded people, like nonretarded people, often have emotional or mental health problems, and their families may require psychological counseling. The Division of Mental Hygiene and Mental Retardation's brochure *Mental Retardation Services in Nevada* recognizes those needs and states that mental health center personnel "may provide diagnostic and evaluation services, individual and family counseling—especially where emotional difficulties are found along with retarded mental functioning—and, in some cases, training for parents." The Division also has a "Director of Psychological Services," who reports to the Associate Administrator for Mental Retardation. In 1974, however, the mental health centers almost never served mentally retarded people, and the person who held the position of Director of Psychological Services for mentally retarded people said flatly that "there are no psychological services for the mentally retarded."²² He said he provided no direct psychological services himself, supervised no one who did, and had no funds to purchase those services. He also said that the staffs of the Rural Clinics program and mental health centers were not giving direct psychological services to mentally retarded people. In addition, the NMHI almost never provides mental health services to its mentally retarded residents. Our interviews with those other programs confirmed the lack of mental health services for mentally retarded people in Nevada.

The two state Mental Retardation Centers (MRCs) are not really staffed to provide mental health services (see Chap. 10). Yet, according to the administrator of the Northern Nevada MRC, the Reno MHC does not accept mentally retarded people or their families for service.²³ She said the Reno MHC staff argues that the MRC staff knows better how to deal with retarded people and their families. The Southern Nevada MRC is on the same site as the Las Vegas MHC, but little interaction occurs between the two. When we asked the administrator of the Las Vegas MHC²⁴ about that interaction, he said that only very occasionally did MRC staff come to the mental health center for consultation, and then usually because it was difficult to decide whether a particular client's problem was primarily a mental health disorder or mental retardation, and hence to decide to which program the person should be admitted. The Las Vegas MHC will accept the client if the mental health disorder is predominant, and then only if the person is only mildly mentally retarded.

²² Interview with D. Rockenbeck, Division of Mental Hygiene and Mental Retardation, Reno, Nevada, August 19, 1974.

Outside the Division of Mental Hygiene and Mental Retardation, the Special Children's Clinics in the Health Division did some counseling of families with retarded children. We described those two Special Children's Clinics earlier (see Chaps. 6 and 7) and noted that some excellent counseling is provided there, but each clinic reaches only families with children under about six years old and has less than one full-time-equivalent staff member devoted to such counseling.

The various Community Training Centers, usually operated by a local Association for Retarded Citizens (see Chap. 11 for details), provide some counseling but are not professionally staffed to provide mental health services. In 1974, for example, the Las Vegas Opportunity Village Association for Retarded Citizens did not provide psychological services to retarded people, but did provide other types of counseling to persons participating in their sheltered workshop and residential living program.** The same was true of the Washoe Association for Retarded Citizens in Reno.

SOME DESIRABLE FEATURES OF A PSYCHOLOGICAL SERVICE SYSTEM

In this section we discuss Nevada's nonresidential psychological service programs in general terms, in relation to desirable features of a mental health service system. This discussion will set the stage for the recommendations given in the last section of this chapter. While our immediate concern is with nonresidential psychological services, the desirable features of a service system discussed here are applicable to many other types of service systems. Still other features could be listed, but the following are some of the major ones to be discussed:

- The system should have sufficient capacity to serve all people whose needs the system is intended to meet.
- Available services should be distributed equitably to the population.
- The service system should function in a coordinated manner.
- Services should be of at least minimally acceptable quality.
- A continuum of levels of services should be available to match people's needs, ranging from outpatient to intensive residential treatment.
- A variety of treatment modalities should be available to match the variety of people's mental health disorders.

These features are laden with words requiring value judgments, but they are nonetheless useful in evaluating existing programs. We believe they encompass the barest essential standards one should expect in a system.

Sufficiency and Equity of Service Availability

A good psychological service system should be able to reach all of those with a substantial need on something approximating an equitable basis. That is, if the public through its elected representatives decides that people with certain types and

** Interview with E. Pillard, Northern Nevada MRC, Sparks, Nevada, August 21, 1974.

** Interview with L. Miller, Las Vegas MHC, Las Vegas, Nevada, July 17, 1974.

** Interview with Dr. Theodore Johnson, Executive Director, OVARC, Las Vegas, Nevada, July 17, 1974.

degrees of mental health disorder need service, then *all* such people should be served. No groups should be excluded on the basis of age, income, accident of geographic location, or the like as they are now. In 1974, for example, Nevadans living in Reno or Las Vegas had a far better chance of receiving psychological treatment than did rural citizens, and adults had a better chance of receiving services than did children.

Coordination of the Service System

Fragmented services and fragmented responsibility are generally undesirable, for they may leave gaps in services and lead to inefficient provision of services, and thus to limited availability and quality of care. This issue is so important that we have treated it separately in Chap. 4. Probably no service system is perfectly coordinated, of course, but Nevada's is very deficient in this regard. The most glaring deficiency with respect to nonresidential psychological services is the lack of coordination between programs as a person is released from a residential treatment program (see Chap. 10 for details).

An important question in a service system should be who is to provide follow-up to monitor the experience of the mentally handicapped client as he or she moves from one service program to another; or even more fundamentally, who is to plan and coordinate an intervention strategy encompassing *all* services needed by the client with a mental health disorder. In Nevada, sadly, the answer to both questions often is *no one*.

Quality of Services

One would like the treatment provided to be of high quality, or at least of minimally acceptable quality. In Nevada, some services are not available at all, and some are of low quality because inadequately skilled people try to provide them. The mental health technicians employed in several Nevada programs are a case in point. As mentioned above, and discussed more thoroughly in Chap. 10, the technicians are generally hardworking, concerned, and dedicated people, but in practice usually bring only the barest minimum of qualifications to the job (see Chap. 10 for details). The official state job descriptions prescribe certain amounts of training they are supposed to be provided, but the amount they actually receive usually is much less. The combination of their low skills and their heavy responsibility for providing psychological services, often without close supervision by senior mental health professionals, leads in our opinion to some clients receiving low-quality services. In Chap. 10 we discuss the same type of difficulty in residential treatment programs.

It is easy enough to say that Nevada could solve the problem by hiring the finest professional talent for all staff positions; but that solution appears infeasible because of the cost and the complex problems of recruiting. Not only are high-quality mental health professionals scarce and expensive, but also they often use noneconomic criteria in choosing job locations, e.g., proximity of high-quality colleagues, living amenities, and opportunities for professional development and advancement. Our conclusion being that it is not practical to eliminate the position of mental health technician, we will recommend upgrading technicians' skills.

Continuum of Levels of Services

Since the types and severity of mental health disorder vary among people, and over time may vary for the same persons, the levels and types of psychological service needed also vary.⁸⁸ The individual patient's needs change as the condition being treated changes—as a result of time (e.g., as the patient's environment changes), as a result of positive returns from treatment (e.g., the acute hospitalizing episode gives way to outpatient treatment and in time to no treatment at all), or as a result of lack of treatment (e.g., a deteriorating untreated situation). It is therefore desirable for a mental health system to offer a continuum of care, a continuum of levels of treatment, from which skilled professionals can select the most appropriate for a given person at a given time. That continuum includes emergency services, outpatient services, day treatment, short- and medium-term intensive inpatient treatment, halfway houses, and longer-term intermediate or low levels of residential service for those with chronic disorders.

In that light, the state of affairs in Nevada is far from good. The treatment options in Nevada hardly constitute a "continuum of care," especially in certain geographic areas. Numerous programs have been created in recent years, but some are too small or otherwise inadequate in relation to the need, despite their glowing official descriptions. The well-intentioned Rural Clinics program is largely one such "paper program." Instead of a continuum, most rural Nevadans with mental health disorders have primarily only two options: outpatient treatment by the small Rural Clinics program, or full inpatient residential treatment at the NMHI. In the Reno area, day treatment for adults is lacking. There are no halfway houses for people with mental health disorders in the entire state, and there is a statewide shortage of longer-term residential care with intermediate levels of mental health treatment for those who need it (see Chap. 10). The nonresidential mental health programs could, but usually do not, provide intermediate levels of services to people with chronic mental health problems who are now living in group care facilities without special mental health services. We are in favor of serving people in the least restrictive and most normal environment possible, but no service can be worse than "too much" service.

To help avoid misunderstandings, a few words of caution are in order. First, the community mental health center delivery mechanism, as it is usually implemented, does not offer the entire continuum of service levels, and was not designed to do so. The original intention was for the centers to provide levels of service supplementary to those of the more traditional mental hospital with its longer-term service. Nonetheless, one of the more obvious difficulties a community mental health center must face is the pressure put on it to serve as a *replacement* unit for the mental hospital. Second, this discussion is not immediately concerned with particular psychological treatment modalities, which are considered in the following section, but with the wisdom of having a continuum of levels of care.

We now turn to a brief discussion of the various levels of treatment for mental health disorders. Our aim is to put the nonresidential psychological services discussed in this chapter into perspective with the other levels of treatment discussed in Chap. 10.

⁸⁸ We are indebted to Dr. Robert Rubenstein for his thoughtful probings and suggestions on the topics treated in this section.

Access Points. For people who need treatment, the diagnostic phase of their experience with the psychological service system is extremely important. In effect it is the access or entry point to treatment, at which it is decided what level on the continuum of care is appropriate for their needs. Its importance for everything that follows in the individual's experience is well known: inadequate or inappropriate diagnosis leads easily to inadequate or inappropriate therapy. Its importance for the overall operation of the system is not as well appreciated as it should be. Certain classes of disorders and various groups of people are more likely to respond well to certain specific levels of treatment than are others. Treatment resources being scarce, the need is acute to match precisely determined needs as well as possible with available services.

The design of access points merits great attention. The features outlined below make up one desirable design for an access point.

The access point can be thought of as a psychological emergency room. Unlike the traditional medical model, however, it should be equipped to provide emergency care on at least an overnight basis if needed. In the structure we envision here, patients enter the system in a state that could be called the "troubled and troublesome." They receive immediate and brief treatment, are thoroughly and rigorously assessed and diagnosed by a highly skilled and well-trained mental health professional, and are given positive referral to appropriate service in the continuum of care.

Let us follow a hypothetical patient through the process step by step to understand better the function of the access point and to see how it might relate to other service components.

The patient comes to the access point, perhaps of his own volition, perhaps because his family or friends brought him, because the police or a general physician encouraged him, or for a variety of reasons. A specially trained mental health worker conducts the initial intake interview to size the patient up and begin assembling the fundamental information needed to make a responsible assessment and intervention judgment. If the patient is in an acute episode, he or she receives on-the-spot treatment. A *highly skilled* mental health professional makes a thorough assessment within 24 hours. This initial judgment is the key to all that follows in the patient's experience; it should be done by the best possible talent the system can afford. It is not a task for a low-skilled, poorly trained, and poorly supervised mental health technician.

Working in conjunction with those in the access point—probably as operational components of a community mental health center—could be a Family Crisis Unit and a Home Visiting Service. The Family Crisis Unit would determine who in the patient's personal circle has a strong enough emotional attachment to the patient to serve as a primary contact and support during the treatment period; that person might be a spouse, a parent, a close friend, or even a professional in a related helping field, such as the ministry. The unit would assess the patient's supporting resources as thoroughly and quickly as possible. Finally, it would provide some information and counseling to the patient's family and friends in an effort to ease their emotional burdens and to facilitate the patient's return to his or her normal setting.

The Home Visiting Service, by contrast, could act as the outreach component (now nearly absent from the Nevada system). Its primary responsibilities would be with the home-bound and geriatric populations. Those groups would include many

people who have recently been in institutions, other recently treated patients, and people who for a variety of reasons are reluctant to seek assistance in the first place. The Home Visiting Service also would provide feedback information about recently discharged patients, e.g., how they are faring, and whether their treatment program seems to have been appropriate and effective. The service unit also would work to prevent the need for patients to reenter more service-intensive components of the psychological service system.

A few general observations are needed on two topics: the kinds of patients likely to present themselves at an access point in the public sector, and the need to concentrate highly skilled resources at the "front end" or diagnostic phase of psychological treatment. The topics are intertwined.

Many people in the mental health professions freely admit that they prefer certain classes of patients over others. The reason may be personal predilections or aversions, or simply that the professional is more successful with some types of patients than with others. The mildly neurotic patient may be more desirable than the acutely psychotic to some professionals; others may regard younger patients as more attractive, interesting, and worthwhile than geriatric ones; or patients with average or above-average intelligence as more "suitable" than those who are retarded; those able to pay higher fees may be more welcome than those who are not; and so forth. This natural sorting and selecting process is more prevalent in the private sector where psychiatrists and other therapists have a choice of patients. One notable result is that the more disordered and harder-to-treat segments of the population are the ones most likely to end up in the public sector. Consequently, a full range of high-quality services is needed all the more in the public sector, which should not have the privilege of accepting only the more "desirable" clients.

At the conclusion of intake and initial assessment at the access point, a service option should be selected depending upon the person's condition. Among those options are direct referral to an outpatient service, to a halfway house, to day treatment, to brief residential treatment in either a general hospital psychiatric unit or in the community mental health center's inpatient unit, and in Nevada, referral to the NMHI. The most likely choice would be outpatient treatment or brief residential treatment.

Brief Inpatient Evaluation and Treatment. The purpose of inpatient evaluation or brief treatment is to deal with the patient's immediate acute difficulty, to the end of returning the patient to as normal a setting as possible as quickly as possible, and to do so with the assistance of a well-considered treatment plan. The emphasis in evaluation, which might extend over a week, would be on resolving the basic question of why residential care was necessary in the first place:

- What elements contributed to the episode? What was the precipitating event?
- What community supports are available to assist the patient's recovery? What personal resources are available?

During the inpatient evaluation period, contacts are made with other helping professionals, the family, and friends, to help in devising an ongoing treatment plan. Patients themselves can be included in the evaluation process to the greatest extent possible, singly and in groups, so as to engage the patient in his or her own plan and

to enable the responsible mental health professionals to see firsthand how the patient handles personal interactions. Some psychological testing could be done to assess mental functioning, and of course a thorough medical examination would be given.

By the end of the 4-to-7-day evaluation period, a plan should have been developed and reviewed with the patient, his or her family or other emotionally supportive people, and the professionals responsible for carrying out the treatment plan. A continuing treatment plan should accompany any and all releases of the patient.

Several possible options exist at this stage:

- Residential care for a short period (up to, say, 30 days).
- Intensive residential treatment for more than a short period.
- Intermediate levels of residential care for chronic cases.
- Day treatment.
- Outpatient care.
- Halfway house.
- Return to family care.
- Return to the community under own recognizance.
- Combinations of the above.

If additional short-term residential treatment is desirable, efforts would be made during this period to engage the person in a therapeutic program that would extend beyond the residential care phase. Efforts would continue to create a "structured life situation," involving work, family, and friends. Medication, individual or group therapy, and work activities would be coordinated to improve the patient's chances in the post-residential-treatment period.

Intensive Residential Treatment For More Than a Short Time Period.

This service is lacking in Nevada, although it is an important and needed service component. First of all, the idea of intensive residential treatment for more than a short time period is meant to encompass a time-frame of from 3 to 12 months—occasionally more. The facility would concentrate on patients for whom intensive therapy is most likely to have positive returns for the resources invested.

Intermediate Levels of Residential Mental Health Care. A chronic weakness in Nevada's current system, this important service gap needs attention. Some people do not need intensive residential treatment but still are not capable of functioning in the community. They need some intermediate level of mental health services. They may need a halfway-house program that helps them make the transition back to the community or prevents their unnecessary placement in an intensive treatment facility, or they may be chronic cases who need long-term residential care with a nonintensive level of mental health services.

Day Treatment and Outpatient Care. These are the two main services provided by the programs described earlier in this chapter. The only remaining point we would like to make about these nonresidential services is that they are not always connected as they should be with the rest of the psychological service system. As far as the client is concerned, the transition from and to nonresidential care should appear to be smooth and care should be continuous. Since changing a patient's primary therapist is difficult, and can disrupt treatment, it ideally would be preferable to have the same primary therapist during both the inpatient and non-residential phases of treatment. Professionals such as psychiatrists or Ph.D.-level

psychologists could be used as the single primary therapist in all phases of treatment. However, the new "Master of Mental Health Services" level of personnel we propose later in this chapter could be assigned the role of primary therapist (with appropriate professional supervision and support) and provide substantial meaningful treatment at relatively low cost compared with using only psychiatrists or Ph.D.-level psychologists.

Range of Treatment Modalities

A variety of approaches exist for treating mental health disorders. Drug therapy and behavior modification are only two examples (and not necessarily mutually exclusive ones) of general approaches or classes of treatment modalities. While the choice of modality should depend on the particular client and his or her disorder, the choice is by no means automatic. The state of knowledge is such that mental health professionals do not always agree on which modality is best for a particular disorder. Nearly all would agree, however, that no single modality is the most appropriate one for all individuals and for all mental health disorders. Nonetheless, Nevada in 1974 did not have a range of treatment modalities in some programs in the public sector. In 1974 some programs in Nevada chose to rely almost exclusively on certain types of behavior modification, while others predominantly relied on drug therapy because they lacked sufficient skilled staff.

Basically, we take the eclectic position that people experience a variety of kinds of mental health problems, which should be dealt with by a variety of kinds of professionals and paraprofessionals in the least restrictive environment possible, employing a variety of approaches and treatment modalities as appropriate to the particular individual's problems. Our orientation is that no one single modality or approach is the best for every client, and hence no one (such as drug therapy or behavior modification) should be used almost exclusively by a mental health service agency.

The remainder of this subsection looks at the issue of treatment modalities in more detail, especially the use of behavior modification techniques, which is a subject of public controversy in Nevada.

The last twenty years have seen extraordinary development and growth in mental health professions and services. The growth has resulted from new information and the creation of new, often competing, views of man. Understandably, the profusion of basic knowledge and theory has led as well to a profusion of therapeutic models or treatment modalities.

New information, including empirical evidence and new theoretical formulations, portends well for a better understanding of how humans function. This information has been generated in a variety of disciplines and specialty fields.⁷⁰ The following is a brief sample listing of areas of development of new information; while sampling and summarization do injustice to subtle details of specific areas, they have the virtue of brevity and aid the reader in picturing the areas generally.

- Psychology has provided much new information from studies of behavior and of human development, from research in experimental psychology, and from clinical

⁷⁰ We acknowledge the considerate assistance of Drs. Leon Wasserman and Martell Bryant, Mt. Zion Hospital, San Francisco, California, in interviews on June 18, 1975.

research and practice. New concepts, such as certain advances in behavior modification, and improvements on previous theories, such as the broadening of psychodynamics to include stress responses, coping mechanisms, defenses, and ego functions, have improved psychology as a base upon which to ground a treatment system.

- Biological sciences, including many newly created sub-sub-specialty fields, e.g., in neurophysiology, biochemistry, and neuroendocrinology, have led to advances in knowledge about neurochemical bases of anxiety, anger, and depression, for instance. The creation and widespread use of various forms of tranquilizing and energizing drugs, due to rapid advances in the psychopharmacological field, have allowed many formerly unmanageable people to be treated effectively. Psychopharmacological intervention has become increasingly important and useful, but primarily as an adjunct to other kinds of treatment (e.g., psychotherapy), which it may facilitate but does not replace.

- Social science has added somewhat to our understanding of people's interactions and functionings within groups, including contributions related to organizations, group dynamics, and value analyses. The notion of "health" or "normal" development and action within the family, the informal and formal group, the organization, the society, and the culture has been the groundwork of much of the social scientific research and thought in the last generation. Some portion of this new information has a bearing on an improved understanding of the causes, consequences, and cures of mental disorder.

Each of these fields, and their associated professions and disciplines, has in a broad sense added to the aggregate fund of knowledge. However, this knowledge remains incomplete and unintegrated as a total body of learning on mental health disorders; consequently, while effective treatments are known for some mental health disorders, thorough and effective treatment and service models have not been developed for every type of mental health disorder.

New and sometimes conflicting service approaches or treatment modalities have springing up in recent years, to a large extent representing manifestations of the expanding but still incomplete knowledge base. In fact, many of the underlying perceptual and theoretical conflicts existing in different disciplinary areas are drawn out into the open in the applications setting. As practitioners have struggled to lessen human suffering, many relatively new or newly improved approaches have surfaced: psychotropic drug therapy, various types of behavior modification, crisis intervention, family therapy, and transactional analysis are examples. No treatment modality is a "sure-fire bet" for effective treatment of all mental health disorders; all have at one time or another had strong supporters and detractors; and most have been able on occasion to help some number of troubled and troublesome people.

It is beyond the scope of this study to attempt to prescribe which modalities should be used for which mental health disorders. We repeat, however, that no single modality is most appropriate for all cases; a complete mental health service system should offer a range of choices. We belabor this point because certain Nevada advocates of behavior modification have told us they feel that in nearly all cases no other treatment modality is needed, and therefore have severely limited the availability of other major modalities in some Nevada mental health programs.

It is true that behavior modification therapies have demonstrated their success in modifying a wide range of types of maladaptive behaviors in some people, but it is shortsighted to ignore other successful approaches, especially when some other

approach is generally more effective for a particular mental disorder. For example, the role of drugs has expanded greatly and has quietly revolutionized the treatment of some mental health disorders. Research in the past 20 to 30 years has demonstrated the high effectiveness of drugs in treating a number of disorders, including some types of severe depression and schizophrenia.⁷¹ Hence, if certain types of personnel effectively are excluded from direct service roles in certain Nevada mental health programs, then effective use of some treatment modalities is likewise excluded (such as chemotherapy, which only physicians with psychiatric expertise are both trained and licensed to provide.)

In the past, behavior modification techniques probably were underutilized in Nevada, but the pendulum now appears to have swung to the other extreme in some programs. Most notable for their use of behavior modification in 1974 were the Clark County Children's Behavioral Services program and the Henderson Mental Health Center program. The Rural Clinics program was equally notable in 1974 for its lack of psychiatric personnel for direct service. By February 1976, however, the Henderson Mental Health Center and the Rural Clinics programs had broadened their mix of staff skills to include psychiatrists and to offer a broader range of treatment modalities. The issue is not whether a program should have psychiatrists or psychologists, but why a program does not have both psychologists and psychiatrists, and thus offer a broader range of treatment modalities. The sole reliance on behavior modification techniques has been criticized not only by psychiatrists but also by psychologists, both in Nevada and nationwide.

There are several behavioristic schools that have contributed to the body of knowledge related to human behavior, but the work of B. F. Skinner and his followers usually comes to mind when one discusses "behavior modification."⁷² Skinner's approach interprets individual behavior as being primarily determined by the individual's past history of reinforcements; past environments (or "contingencies of reinforcements") shape the person's current behavior. Skinner's work has progressed in stages, including the novel *Walden Two*, and the works *Science and Human Behavior* and *Beyond Freedom and Dignity*.⁷³ The last-named met with popular success and acclaim, but also evoked criticism from many scientists and practitioners.⁷⁴ Skinner has responded to his critics in his book *About Behaviorism*.⁷⁵

Behavior modification, a clinical result of Skinner's and many other people's theorizing, emphasizes learning between the subject and his environment. Behavior modification is not one specific method, but rather a family of techniques. In the

⁷¹ Research Task Force of the National Institute of Mental Health, *Research in the Service of Mental Health*, National Institute of Mental Health, Department of Health, Education, and Welfare, Publication No. (ADM) 75-236, Rockville, Maryland, 1975.

⁷² Earlier works include, for example, Pavlov's deterministic theory of the brain and behavior highlighting of the concepts of reflex and conditioning: Ivan P. Pavlov, *Lectures on Conditioned Reflexes*, trans. and ed. by W. H. Gantt, International Publishing, New York, 1941, 2 vols.

⁷³ *Walden Two*, Macmillan, New York, 1948; *Science and Human Behavior*, Macmillan, New York, 1963; *Beyond Freedom and Dignity*, Knopf, New York, 1972.

⁷⁴ Representing various points of view are Joseph Margolis, "Freedom as Determinism," *Transaction*, Vol. 9, September/October 1972, pp. 122-125; Meredith Watts, "B. F. Skinner and the Technological Control of Social Behavior," *American Political Science Review*, Vol. 69, March 1975, pp. 214-227; Raymond J. McCall, "Beyond Reason and Evidence: The Metapsychology of Professor B. F. Skinner," *Journal of Clinical Psychology*, Vol. 28, April 1972, pp. 125-130; and Noam Chomsky, "The Case Against B. F. Skinner," *New York Review of Books*, Vol. 30, December 1971, pp. 18-24.

⁷⁵ Knopf, New York, 1974.

mental health area, behavior modification techniques in general have the characteristic that they are concerned primarily with changing maladaptive behaviors and teaching desirable behaviors.

For a summary of the development of the behavioral approach over the years, see *Progress in Behavior Modification*, edited by M. Hersen, R. Eisler, and P. Miller; two summary paragraphs on the historical course of behavior modification are reproduced below:

One of the foundations of what now is labeled as behavior modification can be traced back to the original work conducted by the physiologists Pavlov and Bekhterev in their animal laboratories at the beginning of this century in Russia. For almost three decades, these two reflexologists conducted numerous animal experiments showing that a previously neutral environmental stimulus (e.g., a bell) when temporally preceding a naturally occurring autonomic response (e.g., salivation in the presence of food) could acquire the power to elicit the autonomic reaction after many such pairings. This phenomenon was later described as "classical conditioning," and a number of the current treatment strategies used by behavior modifiers are derived from the principles of classical conditioning.

Not only has there been a tremendous increase in publications relating to behavior modification in the last decade and a half, but the tenor of the writing has changed over the years. That behavior modification is now truly reaching its adult status is underscored by the absence of acrimonious attacks on other schools of thought, so prevalent in the writings of the earlier behaviorists. This, however, does not mean that most behavior modifiers are willing to compromise and merge their views with nonempirical disciplines, although this merger has been suggested. But it does indicate that the scope of behavior modification has increased and that influences from other empirical approaches are being considered. For example, the importance of physiological processes, the use of drugs as adjuncts to behavior therapy and the role of social psychological factors in the treatment process are subjects for both research and clinical application.⁷⁶

As noted directly above, some mental health service professionals who take a behavior modification approach will use elements usually associated with other approaches, e.g., drugs, in treating clients. To carry the drug example further, another article in *Progress in Behavior Modification* surveys and summarizes findings from four areas where drug research and applied behavior analysis intersect. These areas include:

... (1) drugs as adjuncts that facilitate behavior therapy; (2) environmental interventions that increase the reliability of drug usage by chronic psychotics; (3) experimental analysis of clinical drug effects using direct behavioral observation; (4) drugs as reinforcers, aversive stimuli, or agents of extinction.⁷⁷

The article also states:

Almost 20 years after their introduction, there is no doubt that phenothiazine drugs beneficially alter the deviant behaviors of schizophrenics and that lithium reduces the excessive motor and verbal behaviors of manic patients.

⁷⁶ Especially, see M. Hersen et al., "Historical Perspectives in Behavior Modification: Introductory Comments" in M. Hersen et al. (eds.), *Progress in Behavior Modification*, Vol. 1, Academic Press, New York, 1975.

⁷⁷ R. Liberman and J. Davis, "Drugs and Behavior Analysis," in *Progress in Behavior Modification*.

It is the contention of the authors that withholding these psychotropic drugs when clearly indicated by the patient's behavioral disturbance is tantamount to unethical clinical practice.⁷⁸

Thus, some advocates of the behavioral approach recently have been expanding the range of specific types of treatment they use. The various policy-makers in Nevada can judge from the evidence we present elsewhere in this report on specific Nevada programs, and from inspection of the current operation of those programs, the extent to which this broader behavioral approach exists [in practice] in Nevada. Still, while the behavioral approach has great value, it is neither a panacea nor an all-embracing theory or method.

In reviewing an earlier draft of this report, a Nevada Division of Mental Hygiene and Mental Retardation administrator sent us the following quotation from the Director of the National Institute of Mental Health:

Considerable evidence suggests that behavior-modification therapy in comparison to traditional therapies has several important advantages in work with children. These include greater effectiveness; greater efficiency; greater specificity of results; greater applicability to a wider segment of the population of children; and greater utilization as a treatment method, i.e., groups other than professional personnel in mental health, including parents and teachers, can carry out the behavior-modification process.⁷⁹

Careful reading of the above statement and the rest of the article from which it came shows he does not disagree with the position that behavior modification is not the most appropriate approach for [all] individuals with mental problems. He says in the above quote, "applicability to a wider segment of the population;" he does not say "applicability to [all] the population." Later in the article from which the Nevada Administrator drew the above quotation, we find the following:

... behavior modification is not a method that can be successfully imposed on an unwilling individual. By its very nature, it will succeed only when the individual who is receiving the consequences is responsive and cooperates with the program.⁸⁰

Important and useful though behavior modification is, the zeal of some of its champions is uncomfortably reminiscent of that of some enthusiasts of penicillin who claimed near-omnipotence for the medicine as an antibiotic therapy during its early history. As with many another "miracle drug," actual experience proved to be sobering. Basically, four qualitatively different outcomes were observed in the wake of penicillin's wholesale application: (1) some spectacular results, (2) some modest results, (3) no response or reaction at all, and (4) unwanted, often harmful reactions. In time, those types of cases most likely to benefit from penicillin were identified, and penicillin has taken its place as one important mode of health treatment. The analogy appears to hold for behavior modification.

RECOMMENDATIONS

The problems we have noted with respect to nonresidential mental health serv-

⁷⁸ Ibid.

⁷⁹ Bertram S. Brown, M.D., "Behavior Modification: What It Is—and Isn't," *Today's Education*, January-February 1976.

⁸⁰ Ibid.

ice include: insufficient service capacity to meet the minimum need in each area of the state, especially in rural counties; mental health technicians inadequately trained and supervised in relation to their mental health treatment responsibilities; lack of a continuum of levels of nonresidential services in each area; excessive reliance on a single treatment modality in some programs in 1974; inadequate follow-up service to people released from the Nevada Mental Health Institute; few services to emotionally disturbed children in the schools; and almost no mental health services for mentally retarded people.

We recommend that all professional staff positions at the Las Vegas Mental Health Center be filled. A number of problems noted in this chapter and in Chap. 10 on the center's residential services in 1974 (problems with intake assessment, staff supervision, and smooth transition from one level of care to another) could be resolved if the center had all authorized professional staff positions filled. The Administrator of the Las Vegas Mental Health Center indicates that, as of February 1976, the "vast majority" of these professional positions are filled. The one major problem that cannot be resolved by filling those professional positions is the low skill level of mental health technicians and their lack of training; a subsequent recommendation will deal with this problem for mental health technicians in all programs.

We recommend implementation of improved follow-up treatment to provide a continuity of care for mental health patients released from NMHI; mandatory improved follow-up procedures also should be established to help ensure that people released from other state-operated residential mental health treatment programs (Las Vegas MHC and CBS programs) receive adequate follow-up services. This includes both short-term and long-term follow-up, e.g., for people who have a chronic need for some intermediate level of mental health services and are residing in extended care facilities that do not provide those services. See Chap. 10, on residential mental health services, where this recommendation is developed in detail.

We recommend that 24-hours-a-day emergency crisis intervention service be available from every mental health center and from the Rural Clinics mental health program. Although people with mental health disorders obviously require emergency help at times other than weekdays from 8 a.m. to 5 p.m., some of Nevada's major mental health programs do not have 24-hours-a-day emergency crisis intervention service. This emergency service should include an in-person crisis clinic plus the ability to provide emergency care on an overnight basis if needed, so as to both provide needed service and help avoid unnecessary hospitalization. See the section of this chapter entitled "Some Desirable Features of a Psychological Service System."

Nonresidential mental health services for rural Nevadans are substantially worse, in both quantity per capita and quality, than those available in Las Vegas and Reno. *We recommend that the staff of the Rural Clinics mental health program be substantially increased (at least doubled); that a full range of professional skills be represented on the staff so that a full range of treatment modalities can be used; that the skill levels required of mental health technicians be substantially upgraded as described in a subsequent recommendation; that the present offices in rural areas continue in operation; and that each rural office be visited one day a week by a traveling multidisciplinary team of senior mental health professionals to supplement the lower-skilled rural office staff.* Because it is probably not feasible to staff each

rural office with a full team of professionals, we suggest a set of two traveling teams, each on the rural office circuit about half the time. Thus, skills such as those of a psychiatrist, which are needed for chemotherapy and other modes of treatment but are not needed full time, would be available in each rural area. Local rural office staff would provide outpatient follow-up and emergency services. Traveling teams would complement and supervise the local office staff, assist on difficult cases, and help to follow up discharged residential patients. Residential mental health services needed by rural residents would be provided by the Nevada Mental Health Institute, probably by the same personnel who make up the two half-time traveling teams. Thus, two full-time teams could serve rural residents; each would work half-time with patients from rural areas at the NMHI while the other was visiting Rural Clinic offices. (See Chap. 10.) Also, the current Rural Clinics personnel are spreading themselves thin trying to do many different things. *We recommend that the Rural Clinics staff increase the emphasis on what appears to be the greatest need: service to people with substantial mental health disorders.* The Rural Clinics program is an excellent example of a small embryonic program with admirable goals that exists mainly on paper as far as many rural Nevadans, especially those with the more severe disorders, are concerned.

We recommend that a second community mental health center be established in Clark County. The present Las Vegas Mental Health Center is operating at nearly full capacity and there are still clear unmet needs in the county, e.g., in the areas of follow-up of released residential service patients, service to emotionally disturbed children and adolescents, service to rural residents of Clark County, and service to mentally retarded people with mental health problems. The main problem with the Henderson Mental Health Center is that it is extremely small in relation to the two-thirds of the Clark County population in the geographic catchment area it is supposed to be serving. It does not provide a full range of services and is not located near the center of the population it is supposed to serve. We suggest the present Henderson Mental Health Center be retained as a satellite office of a new community mental health center to be designed on the order of the present Las Vegas Mental Health Center, but located on the opposite side of Las Vegas.

The case for a new community mental health center in Clark County is made in detail in a current proposal by the Division of Mental Hygiene and Mental Retardation.¹¹

Population growth in Clark County that will occur before a new CMHC could be operational (see Chap. 3) adds further weight to the arguments in favor of a new CMHC. No one really knows for sure how many people need mental health services in any of the three major areas of the state, but the existing pressure on the service system in each of the three areas (Clark, Washoe, and rural counties) indicates a need for expanded service capacity. The federal guidelines for community mental health centers recommend that one be established for each 75,000 to 200,000 population. While the reasons for this range are numerous and have been debated from a variety of perspectives, these guidelines are suggestive of what is needed generally to meet the demand for mental health services. Given Las Vegas's current and projected populations, there appears to be ample evidence to support two full community mental health centers for the metropolitan area. The *Clark County Plan for*

¹¹ "Community Mental Health Center, East Clark County." See footnote 10.

Health estimates a need for 28 new psychiatrists in Clark County,⁸² and notes a need for comprehensive mental health services in the Henderson MHC catchment area.⁸³ When a second CMHC is approved, catchment boundaries in Clark County may need redrawing to reflect the realities of population distribution.

In the Washoe County area, the main problem with nonresidential mental health services is that a full continuum of services is not provided. The Reno MHC functions primarily as an outpatient program for adults, but offers a small day-treatment and outpatient program for adolescents. Both programs are operating at full capacity and do not meet the need; people must be turned away. Day treatment for adults is not provided, nor are 24-hours-a-day emergency services or short-term residential care outside the NMHI in Sparks. Rural residents and mentally retarded residents are not now served. Population growth will increase the need for a new community mental health center significantly before it can become operational. We do not believe the Nevada Mental Health Institute should function as a community mental health center for Washoe County; it has enough other functions for which it appears better suited and which will use its staff to full capacity (see Chap. 10). *We recommend that the Reno Mental Health Center be expanded to a full community mental health center on the order of the one now operational in Las Vegas.* The staff and advisory board of the Reno MHC have prepared a proposal for creation of a community mental health center to provide Washoe County with a wide range of mental health services: intake screening and referral, 24-hour emergency services, adult outpatient treatment, adult inpatient evaluation and short-term treatment, adult day treatment, adult extended care, child and adolescent day-treatment, family consultation and outpatient treatment, 24-hour child and adolescent treatment, outreach services, and community consultation, education, and training.⁸⁴ Under the proposal, the center would contract with the Nevada Mental Health Institute for facilities for a short-term (up to 30 days stay) inpatient unit to be staffed by the center. Longer-term patients would be transferred to the regular NMHI program for residential mental health treatment. The Reno MHC might also contract with a local hospital for inpatient space. The proposed extended care program was prompted by the same concerns we express in Chap. 10 about the lack of longer-term intermediate levels of mental health services for people who need them, especially former chronic patients of NMHI. Approximately 100 Washoe County residents needing long-term mental health care are in group care homes that do not offer such care.⁸⁵ The catchment area for the new community mental health center would be all of Washoe County, plus the Lake Tahoe and Carson City areas, since we believe these would be better served by satellite offices linked to a community mental health center in Reno than by the Rural Clinics program, which does not provide a full range of mental health services.

When the northern Nevada Children's Behavioral Services program is fully implemented, the Reno MHC Family Unit service program and staff for children and adolescents should work in close cooperation with it, to maximize coordination

⁸² Clark County Areawide Comprehensive Health Planning Advisory Council, *Clark County Plan for Health*, Las Vegas, Nevada, December 1974, p. F-5.

⁸³ *Ibid.*, p. G-9.

⁸⁴ *A Proposal for the Establishment of a Comprehensive Community Mental Health Center for Washoe County, Nevada*, Reno Mental Health Center, Reno, Nevada, June 10, 1974.

⁸⁵ Interview with R. Keiffer, Reno MHC, Reno, Nevada, April 22, 1974.

of services and continuity of care to children and youth. If the northern Nevada CBS program serves only children under age 13, as the Clark County CBS program now does, there will be a need for services to youths aged 13 to about 18 that the Reno MHC program could concentrate on.

We recommend that the Children's Behavioral Services program provide more complete initial assessment of the mental health problems and service needs of the children it serves than it did in 1974, concentrate more of its resources on children with the more severe mental health disorders than it did in 1974, and broaden the mix of professional skills on its staff to include specifically both physicians with specialty training in psychiatry and psychologists so that a broader range of treatment modalities can be provided. The program in Clark County in 1974 was dominated by one mental health discipline (psychology) and one mode of treatment (behavior modification) that is not always the most appropriate one for every mental health disorder. CBS might be fortunate enough to hire a physician with specialty training in both psychiatry and pediatrics; if not, then the program would also need to provide for pediatric services on at least a part-time consultant basis. In addition, some of the CBS client children whose cases we reviewed may not have had significant mental health disorders. The CBS program justifies serving children with mild behavior disorders by saying serious mental disorders are being prevented; while we fully support the goal of prevention, it is very hard to tell if a serious mental disorder would have occurred in a child with a mild behavior disorder if CBS did not serve the child. See Chap. 5, Prevention, for a discussion of this issue area.

The schools are not presently providing adequate special education for emotionally disturbed children (see Chap. 7), but even if they did, there would still be a need for nonresidential mental health services for the more severely emotionally disturbed children. Rather than try to make the schools into mental health service agencies, we recommend increasing the number of referrals of seriously emotionally disturbed children in school, whether or not they are in special education, to the appropriate mental health center or Children's Behavioral Services program. The schools are not designed to provide every type of service well, nor should they be, since other service programs exist.

We recommend that mental health services be provided to mentally retarded Nevadans and their families who need them. Such is usually not done now.

We recommend substantially upgrading the skills of mental health technicians involved in treatment of mental health disorders by: (1) eliminating the existing personnel classification and creating three new classifications, one for those employees primarily treating mental health disorders, one for those employees primarily providing mental retardation services, and one for those employees who primarily perform nontreatment support functions such as clerical, housekeeping, and patient escort; (2) upgrading the job requirements for the treatment positions to the master's degree level; and (3) creating a training program at the University of Nevada at the master's degree level to provide people skilled in a broad range of mental health services to fill the treatment positions. These recommendations are necessary because, as we have described for certain nonresidential mental health programs in this chapter (and as we will describe in Chap. 10 for residential mental health programs, where the problems are much more prevalent), many mental health technicians currently carry a heavy responsibility for direct treatment of people with mental health disorders although many of them are seriously underqualified

or unqualified to fulfill that responsibility. The job requirements (see Chap. 10) include only a high school education, plus experience and training for higher levels in the "mental health technician" job series. Unfortunately, that training often is clearly substandard; the officially required training levels are low to begin with, and in most cases the Division of Mental Hygiene and Mental Retardation did not appear to have provided even those minimum amounts of training, and certainly had not adhered to the spirit of the training requirements. Each program is supposed to provide that training for its own technicians. At the time of our interviews in 1974, we were told of some very brief training, but saw no high-quality formal training program in existence. In certain cases, such as the Rural Clinics program (where mental health technicians directly treat mental health patients), there was no formal training program at the time of our interviews. A tendency we noted in some nonresidential mental health programs was for the program's administrators to tailor the services provided to fit the skill levels of their personnel, rather than tailoring their personnel to fit the greater service needs (either by revised hiring or revised training policies). Thus, some personnel who do not have the skills to help treat severely mentally ill people are assigned work for which they are more qualified (e.g., parent effectiveness training and premarital counseling) while people with more severe mental disorders go unserved. Recently, some improvement has been made by the Rural Clinics program overfilling some of its technician positions with master's degree level professionals. The NMHI director also told us he is "proceeding to replace mental health technicians with more highly skilled professionals." As of February 1976, the NMHI had converted $2\frac{1}{2}$ such positions. However, as detailed below, the graduates of the proposed university-based work-study program would be skilled in a broad range of disciplines and services needed by people with mental health disorders; they would have significantly broader training than people with master's level preparation in disciplines such as social work or psychology.

Along with upgrading the skills of mental health technicians, certain other changes are necessary. It must be recognized that technicians serving mentally retarded people need different skills from those who serve people with mental health disorders; and much of the technicians' work currently includes escorting people from place to place, housekeeping, and doing other tasks that should not be done by the proposed master's degree level mental health technicians, but should be assigned to people with lower skill levels. The above recommendation clearly will not mean the elimination of all paraprofessionals from mental health service positions, which is neither desirable nor feasible.

The Division of Mental Hygiene and Mental Retardation understandably has been under great pressure, due to the limited number of personnel, to use all available staff to provide services, and it is true that time taken out for training means that both trainers and trainees are not serving patients. However, we believe it is time for a frontal assault on the quality-of-personnel issue. At the very least, it is time to acknowledge through action that psychological services in the public sector are too important to be left to the relatively untrained. The broadest purposes of the proposed University of Nevada master's degree level program are to upgrade the level and quantity of mental health personnel in Nevada and to do so on a continuing basis into the future.

There is a need to train those already active in the service system and to provide a steady source of new talent. In addressing both needs a logical focus is the univer-

sity. In the case of the University of Nevada, coupling the existing psychology program with the nascent medical school program could provide a basis for an improved mental health training program having positive payoffs. At a minimum, the infusion of added professional mental health talent into the university would be a welcome addition. Also, an established training program that offers a university degree should attract desirable trainees who otherwise might not have considered the field.

As we see it, the training program should embody the following features:

- A well-respected teacher-clinician to take responsibility for the overall effort.
- Visiting professionals to provide the best possible instruction and supervision for periods of one month to a full year.
- A work-study schedule devised to make best use of weekends.
- To start, about 12 students entering per year into the 2-year program.
- A program of classroom study and patient contact under supervision that rewards the student-trainee with a professional degree from the University of Nevada, perhaps to be called "Master of Medical Health Services."
- In the interim, until sufficient graduates are produced to staff the service system, provision of more limited training and closer supervision to those already actively working in the service system.

A distinguished professorship could be established at one of the branches of the University of Nevada, perhaps with the title of "Professor of Mental Health Services." It should be well enough funded to attract a truly well-respected person to take the position. It should be awarded for a fixed period of time, not less than about five years, to ensure development and continuity of the program. The professor would be expected to take charge of the mental health services training program and to have the right of access to all other public sector mental health service programs. We are urging a strategy of concentrating resources on one top-notch mental health professional to lead the program, giving him or her an independent base of operations in the university, and mandating training of the current and upcoming generations of mental health servers to levels of excellence well above those now prevailing for mental health technicians. Having a distinguished personage in charge of the program would help to attract other talented people.

San Francisco and Los Angeles have an abundance of highly skilled mental health professionals who could serve as faculty.** It should be relatively easy to get two professionals to fly to Nevada on Friday evening and spend all day Saturday providing instruction and trainee supervision; a possible arrangement might be two hour-and-a-half courses and five hours of direct supervision.

The formal program could be divided into four-month trimesters for a year-round schedule. Each trimester would contain two separate courses; i.e., two different instructors would work simultaneously to teach half the class the first period and the other half the following period, to keep class sizes down and individual contact up.

** San Francisco has an outstanding Department of Psychiatry at the University of California Medical School, and very strong programs in psychology and special education at U.C. Berkeley and San Francisco State, respectively; Los Angeles has several excellent psychological training programs, most notably at UCLA, and Departments of Psychiatry at both UCLA and USC.

The students would be on a four-day workweek in service and spend Saturdays with the visiting teaching staff. They also would receive periodic reviews from and contact with the senior professor in charge of the program. They would be officially attached to the university as students and would receive a wage-stipend through the university of from \$6000 to \$7000 per annum. The students' work experiences would be based on patient contact in public mental health service programs. Additional time would be spent working in other elements of the mental health system, e.g., special education, vocational rehabilitation, and so forth.

At the end of the two-year program, the graduates would be awarded the professional master's degree and provided job opportunities in the Nevada system—perhaps at about \$12,000 to \$14,000 a year to start. Considering what is currently needed, and all the additional slots that would be created as the programs and population grow, the demand for such talent should be excellent and continuing. As outlined above, the new "Master of Mental Health Services" personnel could be assigned the role of being a client's single primary therapist during both the inpatient and nonresidential phases of treatment. With appropriate professional supervision and assistance, this new type of personnel could provide substantial meaningful treatment, with desirable continuity, and at relatively low cost compared with using only psychiatrists or Ph.D.-level psychologists in that role.

The costs for the program would be modest, but the returns would be significant in improved quality of service personnel and in work performed by the students. The faculty costs would be on the order of \$75,000 a year (a distinguished professor at \$40,000 to \$45,000, two part-time visiting teaching staff members at \$10,000 each, plus travel and per diem for the visiting staff of perhaps \$12,000 combined). The student wage-stipends would total \$144,000 per year (24 times \$6000), but they would be earning the wage by working in public mental health service programs.

One major desirable objective of this program is to teach mental health professionals how to create and maintain contact with patients—a nontrivial matter in a situation where there is a usual tendency to avoid making human contact. Another difficulty not to be underestimated is that of maintaining a balance between dependency and patient self-reliance, a balance that obviously shifts in the course of treatment.

Devising every detail of a training program would require more careful thought than is possible here, of course. In any event it should be left to the discretion of the senior professor selected to be responsible for the overall program. Suffice it to say that training first-line practitioners to operate at a level of competence between that of a paraprofessional and a doctoral-level or physician-level professional means that a nontraditional curriculum is going to be needed.

Primary psychological care is person-oriented, generalized, and multidisciplinary—nearly by definition. Thus, there is a need to place such a program within a general-purpose university where the base of educational offerings is large and includes the social, behavioral, biological, and management sciences. The person-oriented aspect of the training is accounted for in the on-the-job component of work; indeed, making a productive tradeoff between work and classroom training will be one of the more challenging tasks.

Specific courses leading to professional responsibility as a crisis therapist, inpatient therapist, and outpatient therapist would be needed and would constitute a core of required knowledge. The basic outline of a two-year training program might look something like the following:

- I. **PSYCHOLOGICAL THEORY AND TREATMENT**
 - Theoretical Concepts in Mental Health
 - Developmental Concepts in Mental Health
 - Concepts of Mental Dysfunction
 - Seminar in Psychopathology
 - Psychological Testing and Measurement
 - Psychological Treatment Methods
- II. **MEDICAL AND BIOLOGICAL**
 - Principles of Biochemistry
 - Introductory Anatomy and Physiology
 - Psychopharmacology
 - Basic Pathology: General Survey
- III. **SOCIAL, CULTURAL, ADMINISTRATIVE**
 - Psychosocial Problems in Culture
 - Mental Health System: A Guide and Overview
 - Sociocultural Factors in Prevention, Diagnosis, and Treatment

This program of study is predicated on a supervised and extensive on-the-job work-training experience, and should enable a successful graduate to work as a productive professional. The need to create a "career ladder" for graduates of the program is important, however, both as a means of clarifying advancement potentials and offering professional identification and recognition. It is conceivable that some graduates would, after a period of service, elect to return to school for more intensive training in one of the mental health specialties, and this program would have prepared them in a rigorous and practical way to do just that.

Another outcome is to teach those actually working in the mental health system to be aware as fully as possible of the number and availability of resources, i.e., to know the system in as comprehensive a fashion as possible. This would be a natural by-product of the rotational features designed in originally. It is another way of trying to cope with the scarcity of resources and the currently scattered, even isolated, elements of the system. Professionals need to know about all sections of the service system to improve its overall operation.

We strongly urge responsible officials to take positive steps to coordinate the mental health operations of the various elements of the mental health service system. The need to monitor and coordinate the flow of patients through the mental health service system is clear when one considers the current lack of referrals, and the lack of follow-up that pervades the service system. We reiterate our recommendation for the creation of Regional Direction Centers to provide needed coordination (see Chap. 4).

Finally, because program management information is deficient, we recommend that a comprehensive information system be established for monitoring mental health program operations, as well as the effectiveness of services. Details of information deficiencies were presented earlier in this chapter, and are also discussed in Chaps. 4 and 10.

Chapter 9

TREATMENT FOR ALCOHOL AND DRUG ABUSE

INTRODUCTION

Prior to the 1960s, most mental health professionals considered alcohol and drug abuse a form of mental pathology. Consequently, they were often treated in the same facilities and with the same techniques used for mental illness. But the past decade has witnessed a major transition. Most drug and alcohol treatment is now administered in separate facilities by a specially trained staff, and this trend appears likely to continue. The reasons for this transition are varied and complex, but we can identify several here.

First, there has been a growing conviction that while the onset of excessive drinking or drug use may ensue from a psychological crisis of some sort, the addiction process once set in motion has its own mechanisms that go beyond the earlier psychodynamics. The release from addiction therefore may require treatment processes relatively independent of those necessary for the earlier psychological problems, and in fact they may take place long after the psychological crisis has subsided.

Second, many alcoholics and drug addicts have strongly resisted being classified as mentally ill, and will avoid treatment in a setting that allows such identification to take place, whether or not that treatment is effective. This resistance is best embodied in the Alcoholics Anonymous (AA) philosophy that the illness is the alcohol dependence itself, and total abstinence is the only remedy. This philosophy may be based in part on moral and religious precepts, but the fact is that AA has probably helped more alcoholics to recover than has any other treatment modality, and any theory of remedy that depends exclusively on psychotherapeutic treatment must contend with AA's success.

Finally, perhaps as a result of these scientific and social developments, the Federal Government has now officially sanctioned a separation of alcohol and drug abuse research and treatment activities from mental health, and has established separate but equal institutes to promote them: the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA). This separation has caused similar reorganization within many states and local communities. While these trends do not mandate separation of all local treatment, education, and prevention activities, as a practical matter the separate funding channels will not discourage differentiation at the local level. Our discussion in this chapter will make a distinction between alcohol and drug abuse treatment programs.

In Chap. 3, on the population needing service, we brought together existing information to assess the magnitude of the alcohol and drug abuse problem in Nevada. This was a necessary first step in a comprehensive planning study of Nevada's service programs. In Chap. 5 we briefly discussed prevention of alcohol and drug abuse. In the remainder of this chapter we first describe existing alcohol and drug abuse treatment service systems throughout the state as a whole, as well as specific characteristics of major treatment programs. This sets the stage for the last two

sections: an analysis of some of the major problems and shortcomings in the existing system, and a set of recommended first steps toward solving these problems. Finally, Chap. 11 discusses the Vocational Rehabilitation program's services for alcohol and drug abusers.

The Nevada Bureau of Alcohol and Drug Abuse estimates that 28,215 cases of drug or alcohol abuse were treated in various kinds of drug and alcohol abuse programs in Nevada in 1974.¹ As will be seen from the program descriptions in this chapter, which covers all the major treatment programs we are aware of in the state, that figure of 28,215 significantly exceeds the number of alcoholics and drug addicts receiving substantial treatment services for their addiction.

The alcohol and drug abuse treatment programs discussed in this chapter expended about \$2.6 million last year, including over \$1.1 million for alcohol abuse and over \$1.4 million for drug abuse. At least 700 alcoholics and 300 drug addicts received substantial service last year from these treatment programs; in addition, more than 700 persons participated in Alcoholics Anonymous in Nevada. Alcohol and drug abuse education programs reached many more.

EXISTING SERVICE DELIVERY SYSTEM

Treatment services for Nevadans suffering from alcoholism and drug abuse are currently supported and dispensed by a number of agencies at the state, county, and community levels. When we add to these levels the variety of purposes, sponsorship, and funding sources represented by those agencies, the resulting service system is a complex one indeed. Furthermore, to speak of an "existing" system is somewhat hazardous, because the system is experiencing considerable flux as state and local organizations grow and as they respond to the newly created NIAAA and NIDA.

The complexity is eased to some extent by the fact that most services are provided within the two regions of Nevada that comprise about three-quarters of its population: the Reno area (Washoe County) and the Las Vegas area (Clark County). Before turning to the regional service agency descriptions for Clark, Washoe, and rural counties, however, it may be helpful to describe the Nevada Bureau for Alcohol and Drug Abuse, which has overall planning and coordination responsibilities. By seeing the relationship between the Bureau and other state and local agencies, such as the Bureau of Vocational Rehabilitation, the Nevada Division of Mental Hygiene and Mental Retardation, and the local umbrella coordinating organizations, the reader will get an overview of the treatment delivery system as a whole.

Nevada Bureau of Alcohol and Drug Abuse

The Nevada Bureau of Alcohol and Drug Abuse was created in 1973 by an amendment to Sec. 458 of the Nevada Revised Statutes. The amendment appears to have been motivated in part by federal legislation requiring a single state agency to receive and dispense federal monies for alcohol and drug abuse programs. Another motivating factor may have been a desire to centralize formerly fragmented units dealing with various aspects of alcohol and drug abuse prevention and treat-

¹ Bureau of Alcohol and Drug Abuse, Rehabilitation Division, Department of Human Resources, *Biennial Report—1973-74*, Carson City, Nevada, January 1975.

ment, in particular by combining the separate and relatively small alcohol and drug programs within a single state agency.

In 1973 Senate Bill 590 gave the Bureau five primary responsibilities as the sole agency for administering the alcohol and drug programs (Sec. 38):

- To formulate and operate a state plan for the development and distribution of prevention and treatment programs, including a survey of needs in this area;
- To formulate and operate a state plan for educating the public about alcohol and other drugs, including a needs survey;
- To formulate and operate a state plan for training teachers and health professionals needed by education, prevention, and treatment programs, including a needs survey;
- To coordinate all state and federal funding of alcohol and drug abuse programs, including dispensing state funds to local facilities (Sec. 50) as well as approval of all applications for state and federal money;
- To develop and publish standards of certification for facilities and exercise authority to certify or deny certification of facilities, noncertified facilities being ineligible to receive state and federal funds.

In 1975 Senate Bill 379 extended the certification powers of the state Bureau to include not only facilities but also programs and personnel.² While the Bureau's planning and coordination functions resemble those of many other states' programs for alcohol and drug abuse, the real teeth of the legislation and the potential power of the Bureau lie in the provisions for dispensing funds to local treatment or education facilities and for certifying the eligibility of those facilities and their programs and personnel to receive state and federal funds. Since the legislation creating NIAAA and NIDA also requires approval from the responsible state agency for any federal grant to a local agency, at least on paper the Bureau has tight control of all federal and state governmental financing of drug and alcohol programs throughout Nevada. As we shall see, however, there are other state and county agencies with some funds and authority in the alcohol and drug program areas.

Internal Structure of the Bureau. The Bureau's main offices are in Carson City. They house a director and six major staff members, not counting secretarial and clerical support staff. The internal organization appears to be differentiated to some extent between alcohol program coordination and drug program coordination, although this is not reflected in their official organization chart.

In addition to the central Bureau staff in Carson City, there is an area coordinator in Las Vegas. Local service agencies in the Reno area receive assistance directly from the central staff; Las Vegas agencies receive assistance first through the area coordinator.

The legislation creating the Bureau did not limit its responsibilities to the five major ones already listed, and the Bureau has already made some operating decisions about how it is going to carry out its mission. Several are worth noting. First, the Bureau has prepared and published two state plans, one for drugs and one for

² Interview with B. Rose, Nevada Division of Rehabilitation, Carson City, Nevada, June 10, 1975.

alcohol. These plans embody some but not all of the planning and survey requirements of the enabling legislation. For example, the state plans do not include comprehensive incidence and prevalence data for alcohol and drug abuse (see Chap. 3 of this report for a discussion of the limited available data). Also, the plans contain relatively little discussion or information about specific needs in either treatment or training programs, particularly those for alcohol. At the present time the plans primarily amount to a broad statement of goals and a description of existing treatment agencies throughout the state.

The Bureau has also decided to implement data collection systems for evaluation and monitoring of alcohol and drug abuse programs. The first of these to be implemented is named IDARP, a reporting system for drug abuse programs; the state has received an NIDA grant for this purpose. No action has been taken as yet on an alcohol program monitoring system.

Finally, the Bureau has elected not to engage in providing treatment services, leaving that to local community agencies. Its role will be confined to coordination, education, certification, and training; in the realm of treatment services, its only role will be to make grants to local service agencies from state funds or help them find other funding sources.

Relations Between the Bureau and Other Agencies. Although Sec. 458 of the Nevada Revised Statutes appears to give the Bureau virtually total control of alcohol and drug programs throughout the state, a number of other agencies still maintain substantial responsibilities in that field, either directly or indirectly. Together with the Bureau's own "umbrella" organizations for coordinating programs in the Reno and Las Vegas areas, they form a network of crisscrossing direct and indirect relationships, some of which are portrayed in Fig. 9.1. The solid lines represent direct administrative authority or direct service provisions; the dotted lines indicate influence but not direct control. Most influence is in the form of financial assistance and certification of programs; another form of indirect influence is the facility approval function of the Comprehensive Health Planning (CHP) agencies. We note that most direct service for alcohol and drug abusers is not provided by government agency programs.

Umbrella Organizations. The state Bureau has recognized two umbrella organizations for local alcohol and drug abuse treatment programs: NASAC (Northern Area Substance Abuse Council) for the Reno area, and SNDAC (Southern Nevada Drug Abuse Council) for the Las Vegas area. To some extent the umbrella organizations represent a partial decentralization of the Bureau's coordination functions. Their primary responsibilities are to develop master plans for the local area, to build good working relations with community leaders and local funding sources, and to help local programs that are seeking state and federal funds. They are private nonprofit organizations that receive most of their operating funds from local and state grants (as in the case of NASAC) or federal grants (as in the case of SNDAC). Like the Bureau, the umbrellas are officially clearing and coordinating houses whose primary function is not the provision of direct services. SNDAC has a large grant from NIDA, however, and does operate some treatment service programs.

Although local agencies are encouraged to affiliate with the umbrella organizations, such affiliations are not required by the state Bureau and in fact there are a number of local agencies receiving state funds that are not so affiliated. A local agency may apply for state funds directly to the Bureau in the north or through the

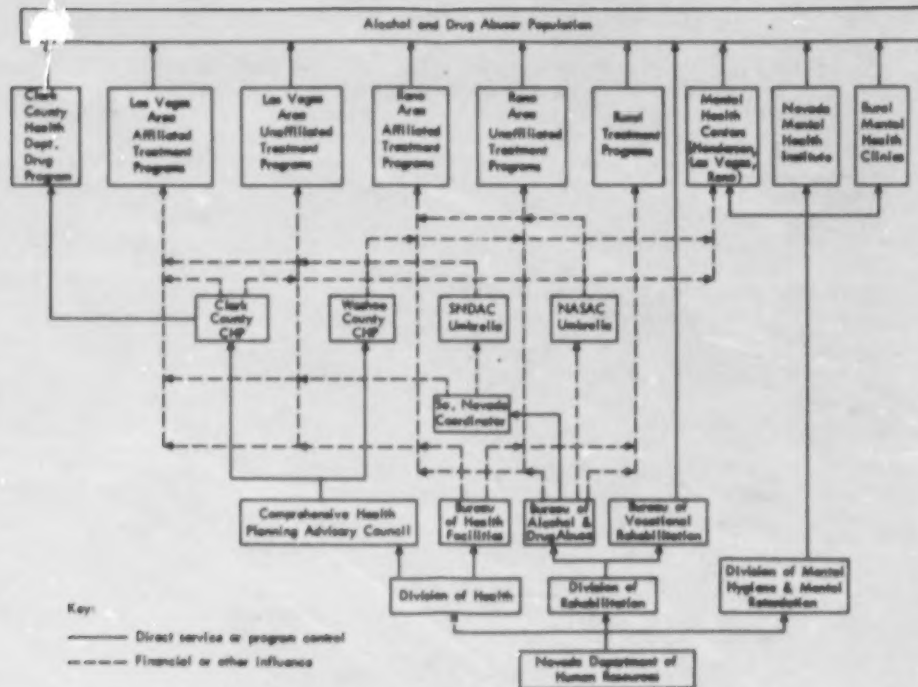


Fig. 9.1—Organization of major alcohol and drug abuse treatment programs in Nevada

Area Coordinator in the south; however, copies of all such applications are sent to the appropriate umbrella organization for review prior to final disposition.

Expenditures of the Bureau of Alcohol and Drug Abuse. The state Bureau of Alcohol and Drug Abuse receives its major funding from several sources and passes some of it on to local education, training, and treatment programs in the form of state grants. Table 9.1 is a summary of estimated income and grant expenditures.

The total funds for grants amount to about \$330,000, or about 50 percent of the total uncommitted income (i.e., the state allocation and federal formula grants). The bulk of these grants go to treatment agencies for the provision of direct services. Most of the remaining funds support the personnel and overhead costs of the Bureau and its Las Vegas office. Of course, since some of the Bureau's staff time is spent giving lectures and in public education projects, some of these funds might properly be listed under education.

Division of Mental Hygiene and Mental Retardation

The Division of Mental Hygiene and Mental Retardation has several major subagencies that provide direct service to alcohol and drug abusers. The most important is the Nevada Mental Health Institute (NMHI), whose "Ward 10" is the only comprehensive inpatient treatment facility for alcohol and drug abusers in the state of Nevada (see Chap. 10 for a description of the Nevada Mental Health Institute).

Table 9.1

**FINANCIAL RESOURCES AND SELECTED EXPENDITURES OF THE
NEVADA BUREAU OF ALCOHOL AND DRUG ABUSE, 1975**

Source or Receiver	Approximate Amounts	
Income		
State budget		\$384,000
Federal formula grant: alcohol		200,000
Federal formula grant: drugs		100,000
Drug monitoring system (IDARP)		128,000
OEO occupational program grant		51,000
Total income		<u>\$863,000</u>
Grant obligations ^a	<u>Alcohol</u>	<u>Drugs</u>
Umbrella organizations ^b		
NASAC	\$ 12,500	\$ 12,500
SNDAC	27,280	
Education		102,978
Training	9,000	
Treatment programs ..	<u>94,400</u>	<u>70,200</u>
	143,180	185,678
Total grant obligations		<u>\$328,858</u>

SOURCE: Interview with Paul Cohen, Nevada Bureau of Alcohol and Drug Abuse, November 1974.

^aIncludes both actual and potential commitments.

^bSome of these funds are used for treatment, and some for administrative purposes.

Ward 10 is not affiliated with the NASAC umbrella at the present time; it receives all its funding from the Division of Mental Hygiene and Mental Retardation without involvement of the state Bureau of Alcohol and Drug Abuse. While NMHI primarily serves alcohol abusers of the northern areas, a client can be admitted from any part of the state. NMHI is the only facility that can receive court-committed cases of alcohol and drug abuse that are processed under existing mental health statutes.

The Division of Mental Hygiene and Mental Retardation also operates three Mental Health Centers (MHCs) serving the Henderson, Las Vegas, and Reno areas. These Centers handle some alcoholism cases on an outpatient basis, but at the present time none is a major service delivery agency for alcohol and drug abuse clients, and only the Las Vegas Mental Health Center has a specific alcohol program (outpatient group therapy).

Finally, the Division of Mental Hygiene and Mental Retardation has a Rural Clinics program for providing mental health services to outlying regions (see Chap. 8 for a description of the program). Although these clinics do not appear to provide direct services to many alcohol and drug abusers, they are supposed to act as screening agencies for clients admitted to NMHI.

County Comprehensive Health Planning Agencies

The County Comprehensive Health Planning agency performs various functions for the State Comprehensive Health Planning Advisory Council. Among other things, this council and its county counterparts advise the Nevada Bureau of Health

Facilities regarding licenses to operate health care facilities. The Clark County CHP is quite active and, for example, is the recommending authority for facility licensure of the Las Vegas Mental Health Center.

The Clark County CHP also has a Substance Abuse section, responsible for preparing recommendations for alcohol and drug abuse facilities. Alcohol and drug treatment program facilities currently come under the definition of "health care facilities" and are therefore required to have licenses from the Bureau of Health Facilities with proper approval from the CHP. One may conclude that the facility certification function of the Bureau of Alcohol and Drug Abuse and the facility licensing function of the Bureau of Health Facilities overlap and could conflict.

Nevada Bureau of Vocational Rehabilitation

The major function of the program operated by the Bureau of Vocational Rehabilitation is not to treat the alcohol or drug abuser, but to provide vocational services. VR expenditures for alcohol and drug abuse were approximately \$150,000 in FY 1974 (of which about 56 percent was for drug abusers). VR service was completed for 140 alcohol and drug abuse clients in FY 1974 (of whom about 46 percent were drug abusers). The program is fully described in Chap. 11, with breakdowns of data specifically for people who have had alcohol and drug abuse problems.

We now proceed to an overview of local treatment programs for alcohol and drug abuse in the Reno, Las Vegas, and rural areas.

Treatment Programs in the Reno Area

Most of the treatment specifically for drug and alcohol abuse in the Reno area is provided through the seven programs listed in Table 9.2. Since most of these programs are or have been affiliated with the NASAC umbrella, it would be appropriate to start with the role of that organization in the service delivery system.

The NASAC Umbrella. The Northern Area Substance Abuse Council has evolved through several stages and councils since 1964. In 1964 it was called the Washoe County Council on Alcoholism, at which time it was an umbrella organization for alcohol treatment programs. In March 1974, apparently in response to requirements of the state Bureau of Alcohol and Drug Abuse for umbrella organizations, the council name was changed to the Washoe County Council on Alcohol and Drug Abuse. This was accompanied by some conflict with an organization called DETRAP, which had viewed itself as the unofficial umbrella organization for drug treatment programs prior to the creation of the Bureau. This conflict resulted in another name-change by the council to the current "NASAC" in September 1974. DETRAP was originally funded by the City of Reno and by a federal grant from the National Institute of Mental Health (NIMH). At one time it had its own treatment programs; Omega House was initially a part of DETRAP, but it has pulled away recently. At the present time the state Bureau has named NASAC as the official umbrella organization for both drugs and alcohol, and it appears that DETRAP may be relatively inactive.

NASAC had an operating budget of about \$57,000 in 1974, of which \$17,500 came from the state Bureau, \$18,500 from the City of Reno, \$9,500 from the City of Sparks, and \$11,500 from Washoe County. This supports a director, an assistant director, and a secretary, all of whom are full-time, and a suite of two offices.

Table 9.2
MAJOR ALCOHOL AND DRUG ABUSE TREATMENT AGENCIES IN THE RENO AREA

Agency Name	1974 Umbrella Affiliation	Public or Private ^a	Treatment Setting	Estimated 1974 Client Capacity	Average Length of Stay	Estimated Annual Budget	Major Funding Source
<u>Alcohol</u>							
Alcoholic Rehabilitation Association (ARA)	Active	Private	Live-in, work and therapy	22	3-4 mo	\$96,000 ^b	Client fees
Beacon House (women only)	Active	Private	Live-in, therapy	9	1-2 mo	\$7,200 ^b	State grant; facilities fully owned
Nevada Mental Health Institute (NMHI, Ward 10)	None	Public	Inpatient work and therapy	28	2-3 mo	\$415,000	State
Washoe State Rehabilitation (men only)	Inactive ^c	Private	Live-in, work	16	3 mo	\$35,000	Client fees
Alcoholics Anonymous	None	Private	Outpatient meetings	200	—	—	None
<u>Drugs</u>							
Omega House	Active	Private	Outpatient counseling	190/yr	—	\$115,000	State grant
Entitas Foundation	Inactive	Private	Live-in, work and therapy	30 ^d (62/yr)	1 yr ^e	\$56,000	Operationally self-supporting ^f

^a"Public" means that agency authority stems directly from the state and local government.

^bExcludes funds for counseling personnel, which are administered directly by NASAC. In 1975 the state grant affiliation with NASAC ended.

^c"Inactive" means that the agency is receiving no funds or direct assistance from NASAC.

^dIncludes non-drug-addict clients.

^eVaries from 1 week to 6 years.

^fFor example, a hog ranch, health spa, and hay business are operated.

In addition to these funds NASAC also has a special grant of \$37,000 to support a counseling program for ARA and Beacon House, two live-in treatment organizations, as well as a counselor training program that is conducted mainly at ARA. Interestingly, it appears that in the future NASAC may not act as a funding "conduit" to local treatment programs. It is reported that because of red tape and administrative procedures, it is easier for the local treatment agency to apply directly to the state, with assistance and advice from NASAC. This means that NASAC will be neither a direct provider of treatment facilities nor a provider of financial assistance to local treatment facilities.

Alcohol Programs in the Reno Area. There are more programs for alcohol abusers than drug abusers in the Reno area. The two programs that appear to be the most stable and the most illustrative of professional treatment standards are NMHI's Ward 10 and the ARA. Both have full programs emphasizing a combination of work and treatment; the ARA provides about two hours of group and one hour of individual therapy or counseling each week, while NMHI provides about nine hours of group therapy. Both stress regular work as well, with NMHI clients working inside the Institute and about half the ARA clients working in outside jobs. They also have a greater number of treatment staff with professional training (in relation to the number of clients) than does the average treatment program in the state. Ward 10 has a director with an M.S.W. and long experience in the alcoholism field and a psychiatric L.P.N. with certification for psychiatric services; they provide most of the group therapy, with the director conducting confrontation group counseling and the L.P.N. conducting ego or supportive group counseling. ARA has the services of five counselors, two of whom are part-time and hold higher degrees (master's and Ph.D.) and two of whom are full-time recovered alcoholics who have received in-service training.

The main differences between Ward 10 and ARA are in the treatment setting and financing. Ward 10 is a full inpatient program within a state-funded mental institute. At ARA, of course, entry is voluntary and most clients work on the outside, so in this sense ARA is more like a halfway or recovery house. Since most of its financial support comes from client fees, ARA tries to avoid the skid row alcoholic or other types of clients who are unable or unwilling to work. On the other hand, NMHI is supported entirely by the state, so there is no self-selection on the basis of employability.

The other alcohol programs are less comprehensive from a treatment point of view. Beacon House is a relatively small program for women only; until the arrangement terminated in 1975, it offered some counseling service from a Ph.D. psychologist provided by NASAC, with each client receiving two hours of group counseling per week. Washoe State Rehabilitation is strictly a work program with no psychotherapeutic counseling. Finally, there are several chapters of Alcoholics Anonymous including chapters at ARA, Beacon House, and Washoe State. As in most parts of the country, the AA in the Reno area accounts for the great bulk of alcoholics who seek help for their problem.

Drug Programs in the Reno Area. There are only two major programs for drug abuse treatment in Reno, and one of these accepts non-drug-abusers as well. The Entitas Foundation is a live-in therapeutic community that accepts persons with any type of "problem," but most of the problems are drug-related. Entitas is staffed by former clients who have completed its therapeutic program. The forms of

treatment include work, a relatively stable social community, and group sessions of residents. Entitas operates a hog ranch, a mineral bath and spa, a haying business, and a trailer court which render it operationally self-supporting, and the residents work in these businesses. Interviews with its director, Wes Brown, reveal plans for expanding Entitas to accommodate 250 residents if funding can be secured.

The Omega House is the major outpatient drug treatment facility in the Reno area. It offers counseling on an outpatient basis only, but apparently has future plans for some type of live-in facility as well. The program employs five counselors; four are paraprofessionals, but the director has a master's degree and considerable experience in the field. All types of counseling are offered, including individual, group, and family. The mode is once per week for most clients. Most of the clients are youths with pre-addiction problems involving soft drugs.

In addition, a small fraction of NMHI Ward 10 patients are drug abusers but the program is designed for alcohol abusers. There are no detoxification facilities for hard-core heroin addicts, even though the figures in Chap. 3 suggest that opiate addiction may be a serious problem in the Reno area.

Treatment Programs in the Las Vegas Area

The treatment situation in Clark County is in some ways opposite from that in the Reno area (see Table 9.3). While Reno has more facilities for alcohol abusers, Las Vegas has far more facilities and expenditures for drug abuse, even though our incidence analysis shows alcoholism rates to be higher in the area than drug abuse rates. The reason may be tied to the particular history of the Southern Nevada Drug Abuse Council (SNDAC), the umbrella agency for the Las Vegas area.

The SNDAC Umbrella. Until November 1973 SNDAC was the umbrella agency for drug programs, after which time it was recognized as the umbrella for both alcohol and drug programs.

There are other differences between SNDAC and NASAC. While NASAC serves mainly as a coordinating agency and tries to stay out of direct service delivery, SNDAC has taken a different service path by initiating several in-house treatment programs. The major basis of this thrust is a large grant SNDAC has received from NIDA; current funding is at the level of about \$500,000 a year. Apparently, the terms of this grant require that the umbrella provide some in-house facilities, although the bulk of these funds is channeled out through subcontracts to local affiliates that provide direct treatment services. SNDAC also receives some funds from the state—\$50,000 for drugs and \$40,000 for alcohol—as well as about \$225,000 from other sources in the form of goods, services, and cash donations. In sum, SNDAC is funded at a level of over three-quarters of a million dollars a year.

The central staff includes a director, an assistant for programs who is responsible for monitoring SNDAC's subcontracted drug treatment agencies, an alcoholism program coordinator, and some clerical and business management personnel. There are also some treatment staff for their in-house direct service programs (described later in this chapter). SNDAC has an extremely large board of directors—about 150 members—who meet periodically to guide SNDAC's overall policies.

SNDAC sees its role as somewhat broader than that of NASAC; it feels it should monitor and advise on specific grant applications to state and federal agencies from local programs, do communitywide planning, and be responsible in a general way for fund raising for all local programs affiliated with the agency. In this connection

Table 9.3
MAJOR ALCOHOL AND DRUG ABUSE TREATMENT AGENCIES IN THE LAS VEGAS AREA

Agency Name	1974 Umbrella Affiliation	Public or Private	Treatment Setting	Estimated 1974 Client Capacity	Average Length of Stay	Estimated Annual Budget	Major Funding Source
<u>Alcohol</u>							
Comprehensive Alcoholism Recovery Services (EOB) ^a	Inactive	Private	Live-in, work and therapy	20	2-3 mo	\$100,000	Federal grant (NIAAA)
Community Alcoholism Centers (2) (EOB)	Inactive	Private	Information and referral, some outpatient counseling	40/mo	—	\$42,000	Federal grant (NIAAA)
North Las Vegas Hospital	None	Private	Inpatient	20	(b)	(b)	Client fees
SNDAC	Active	Private	Outpatient counseling	42	—	\$68,000	State grant
Sunrise Hospital	None	Private	Detox plus outpatient counseling	10 + 60; 527 detox per year	—	—	Client fees (\$150/day + \$10-20/mo)
Alcoholics Anonymous	None	Private	Outpatient group meetings	500	—	—	None
Las Vegas Mental Health Center	None	Public (state)	Outpatient group therapy	126/yr	—	~\$20,000 ^c	State
<u>Drugs</u>							
Addiction Treatment Clinic	None	Public (county)	Outpatient methadone	90	Indef.	\$60,000	Client fees (\$50/mo)
Family, Inc.	Active	Private	Live-in community	14 (30/yr)	1 yr	\$195,000	Federal grant (NIDA)
Fitzsimmons Halfway House	Active	Private	Live-in	6	2-6 mo	\$62,000	Federal grant (NIDA)
Latino Project	Active	Private	Outpatient counseling	5	—	\$31,000	State grant
NIKE House	Active	Private	Live-in, teen-age girls	5	3 mo	\$52,000	Federal grant (NIDA)
Operation Bridge	Active	Private	Outpatient counseling	49	—	\$52,000	Federal grant (NIDA)
SNDAC Clinic	Active	Private	Outpatient counseling	44	—	\$135,000	Federal grant (NIDA)

^aEconomic Opportunity Board is the grantee; this is a new program that started January 1, 1975.

^bThis is a new program that started in December 1975.

^cActual expenditures are not reliably known, and are part of the overall LVMHC budget.

some questions might be raised about potential overlap between the jurisdiction and duties of SNDAC and the local coordinator in the state Bureau's Las Vegas branch office. Further, at the present time there is apparently no formal or informal relationship between SNDAC and the relatively active Substance Abuse section of the Clark County Health Department.

Alcohol Programs in the Las Vegas Area. In contrast to the Reno area, there are relatively few major alcoholism treatment programs in the Las Vegas area other than the traditional AA chapters, even though the Las Vegas area probably has more than three times as many alcoholics as the Reno area. One program, Comprehensive Alcoholism Recovery Services, is just getting under way with a new grant from NIAAA. It will be a halfway house or recovery home emphasizing both detoxification and relatively long-term care; work and psychotherapeutic counseling will be provided. It will have a director with considerable experience in alcoholism counseling (currently working in one of the EOB Community Alcoholism Centers), a full-time counselor, and a half-time nurse for the nonmedical detoxification unit. In spite of this relatively comprehensive program, the service will be able to handle only 16 live-in and 4 detoxification clients.

In December 1975, the North Las Vegas Hospital opened a 20-bed alcohol treatment center that includes a hotline, a detoxification unit, and an inpatient program; the program's multidisciplinary team utilizes a multiple treatment approach, including self-help, social work with the alcoholic's family, and individual and group work with a psychologist.³

The only other detoxification service available to Las Vegas area residents is offered by Sunrise Hospital, but this is only on a fee basis at the rate of \$150/day (many clients apparently pay this with medical insurance). The alcoholism counselor at Sunrise also has several outpatient counseling groups, most of whose members enroll following detoxification.

It is worth pointing out here that until recently two other agencies offered detoxification and some inpatient care: Southern Nevada Memorial Hospital and Cedarbrook Hospital. Southern Nevada receives support from the county for indigent patients. At present, however, it accepts detoxification cases only in medical emergencies (e.g., severe withdrawal symptoms), and its psychiatric ward—Ward 700—does not accept patients with a primary diagnosis of alcoholism. Cedarbrook formerly handled drug and alcohol detoxification as well as a methadone maintenance program under subcontract from SNDAC, but it has recently terminated that service.⁴ It seems clear that, given the size of the alcoholic population, the Las Vegas area has insufficient nonmedical detoxification facilities.

SNDAC offers an outpatient counseling service; the counseling is all one-to-one and is handled by a full-time counselor (with a Ph.D. in philosophy) and the alcoholism coordinator (with an M.A. in psychology). Most of the clients have been committed by a court for DWI offenses (Driving While Intoxicated). Some outpatient counseling, as well as information and referral, is provided at two Community Alcoholism Centers under EOB auspices. The area has no other outpatient services for alcoholics with the exception of a single small alcoholic group at the Las Vegas Mental Health Center.

³ "Alcohol Rehabilitation Unit Stages Open House," *Las Vegas Review Journal*, December 5, 1975.

⁴ In August 1975, the current owners of Cedarbrook Hospital applied for approval to operate a 24-bed alcoholic hospital facility. See "Task Force Okays Alcoholic Hospital," *Las Vegas Review Journal*, August 28, 1975.

The local Economic Opportunity Board maintains two "Community Alcoholism Centers," but they are primarily information and referral centers that do some informal counseling. The problem these centers have is that there are few places to which they can make referrals.

Not shown in Table 9.3 are two residential facilities—We Care for women and Samaritan House for men. Other than AA, they have no treatment services per se and serve primarily as temporary shelters.

Drug Programs in the Las Vegas Area. All but one of the drug programs in the Las Vegas area are affiliated with SNDAC and are at least partially funded by SNDAC's NIDA grant. They represent a fairly wide range of services, but some operate at less than capacity. Operation Bridge is an outpatient counseling program focusing on young pre-addicts involved with soft drugs. It has two full-time counselors, both of whom have master's degrees in counseling; individual, group, and family counseling are offered. Bridge also has a hotline that averages 500 calls per month.

Fitzsimmons and Family, Inc. are live-in facilities. Family, Inc. focuses on a therapeutic community for the hard-core addict, and Fitzsimmons on creating social and vocational stability for the post-addict. Both apparently have had high turnover and some staffing problems. In addition, both have been embroiled in public controversies over alleged availability of drugs.

NIKE House is a live-in facility for adolescent girls, and the Latino Project is a similar facility for Mexican-American drug abusers. Both programs focus on the young pre-addict involved with soft drugs. The Latino Project has also had some staffing problems and may not be funded by SNDAC, at least in the short-term future.

The SNDAC Clinic is the only outpatient facility for drug abusers. It employs a part-time psychiatrist, a full-time psychologist (M.A.), a full-time counselor (B.A.), and two paraprofessionals. Many of the cases come from court assignments, and this unit also does considerable diagnostic evaluations for the court.

The Addiction Treatment Clinic, sponsored by Clark County, is the only methadone maintenance program in the Las Vegas area and in the state. Its headquarters are at the Southern Nevada Memorial Hospital (although it is strictly an outpatient program). The county sponsors the program but does not have to contribute much money to it since it is financed mostly by client fees. This means, of course, that most clients must have relatively stable employment. The Clinic is not currently affiliated with SNDAC and receives no funds from the state.

Treatment Programs in Rural Areas

Aside from several AA chapters and some small amount of outpatient counseling in a few of the rural counties, there are few treatment programs outside of Clark and Washoe counties. A major exception is the New Frontier program in Fallon, which offers detoxification (18 beds) and counseling services to clients throughout a large part of central Nevada. Another is the Elko Council on Alcoholism, which recently received funds from the state Bureau for an alcoholism counselor and has a caseload of about 100 clients. Two other programs serve rural substance abusers: the Nevada Mental Health Institute program described above, and the program for Indians noted in the next subsection.

Treatment Programs for Special Populations

Other treatment programs deal with special types of clientele. These include the Veterans' Administration hospitals or clinics and the Indian programs.

VA Hospitals in Reno and Las Vegas. The VA has a clinic in the Las Vegas area and a hospital in the Reno area, but apparently neither has an alcoholism program as such. Some alcoholics (about 6 in late 1974) are handled on an outpatient basis in the Las Vegas clinic, but those requiring inpatient care are referred to VA hospitals in other states—particularly the San Diego VA Hospital in California.

Indian Program. There is an Intertribal Council Alcohol and Drug Abuse program for Indians with headquarters in Reno. It is supported in part by an NIAAA grant of \$211,000. Currently, only outpatient counseling is offered at 10 satellite sites throughout the state. The program has three counselors, each of whom maintains a load of about 20 clients. There is no inpatient rehabilitation facility, but the program is applying for an NIAAA grant that will provide one if the grant comes through. Some detoxification services are offered at the Schurz Indian Hospital and the Duck Valley Hospital.

PROBLEMS IN THE CURRENT DELIVERY SYSTEM

Investigation of the service delivery system for alcohol and drug abuse treatment has revealed a number of gaps between people's needs and services available in current programs. Some of these gaps are readily apparent from the information presented in the preceding sections; other deficiencies became apparent during our interviews with many persons involved in program coordination and direct service delivery. The problems fall into three categories:

- Inadequate information
- Organizational problems
- Facility and service deficiencies

We must stress that our investigation was not so comprehensive as to uncover all the problems that must exist in the growing and complex field of alcohol and drug treatment programs in Nevada, but we are confident that the problems discussed below are the most urgent and pressing.

Inadequate Information

One indication of the information problem in the alcohol and drug abuse field is the fact that we had to develop improved estimates of alcoholism rates in Nevada (see Chap. 3). Just as the analysis and recommendations in this report require information about the magnitude of the alcohol and drug abuse problem in Nevada, so any state or local planning effort must have such data if it is to develop and operate adequate and realistic service programs for those in need.

At a minimum, two types of information are required for proper planning and evaluation of alcohol and drug programs, and are now deficient in Nevada:

- Information about rates of alcohol and drug abuse
- Information about existing treatment programs and their clientele

Chapter 3 summarized the deficiencies in information on rates of alcohol and drug abuse. For alcohol abuse, three separate data sources and methods of estimating the statewide level gave reasonably consistent results; however, estimates of the same quality for different regions of the state were not developed. For drug abuse rates, the data base is of much lower quality; for obvious reasons there is no reliable information on sales, and there is no readily countable physical manifestation of drug abuse comparable to cirrhosis deaths from alcohol. The Nevada state survey⁴ just completed by the Gallup polling organization for the Nevada Division of Rehabilitation does not solve the problem of estimating the drug abuse rate, since the population is unlikely to have accurately self-reported illegal hard-core drug addiction.

The second information gap has to do with the current service delivery system. There is inadequate systematic detailed data collection on client loads, staffing, service capacity, funding levels, and the like for treatment programs throughout the state. Intelligent planning under such circumstances becomes very difficult. The information presented in Tables 7.2 and 7.3, and in the previous section, was gathered from numerous time-consuming interviews; while we make no guarantee of its accuracy, it is nonetheless better than any information we could obtain from a single source in mid-1974. In sum, the state has insufficient routine program management information, and little information on program results—clients' conditions following release from treatment—to use in program evaluation.

The state Bureau of Alcohol and Drug Abuse is planning to install IDARP, which will go a long way toward closing both information gaps for drug programs. However, this system is not appropriate for alcohol programs. The Nevada Bureau of Alcohol and Drug Abuse has recognized this lack of information and its 1975 *Nevada State Plan for Prevention, Treatment and Rehabilitation of Substance Abuse* presents plans to begin remedying the situation.

Organizational Problems

Some of the organizational problems in the present service delivery system became apparent in earlier discussions of Fig. 9.1. Even though the state Bureau of Alcohol and Drug Abuse was created to consolidate formerly fragmented units within the state government into a single coordinating state agency, the fact is that there are still several important areas of overlapping or ambiguous jurisdictions, which already have created some conflict and promise to create more.

The first overlap involves the state Bureau and some of its own creations, the local umbrella organizations. Basically, both groups seem to have responsibility for overall coordination of community programs. At first glance one would assume that the umbrellas handle local community coordination and the Bureau handles coordination at the state level. That arrangement would be sensible for a large state like California where there are so many local communities that state and local coordination really are two distinct processes. But Nevada has only two large communities. Consequently, it is not clear why the central office in the Reno area cannot handle Washoe County coordination (particularly if they were located in Reno instead of Carson City) nor why the Las Vegas branch office cannot handle coordination for

⁴ J. Pollard, *Survey of Nevada Rehabilitation Needs, 1975*, Nevada Rehabilitation Division, Carson City, Nevada, 1975.

that area; indeed, the branch director's title is "area coordinator." The umbrellas, as they presently are constituted, appear to be an unnecessary bureaucratic layer between the local service delivery agency and the state Bureau. The Bureau has already acknowledged this to some extent by allowing programs to apply directly to the central staff for state funds without going through the umbrella, and the complexity of subcontracting with state monies may accelerate the trend in that direction. SNDAC's subcontracting role is with federal and not state funds. Also, some local treatment programs are not affiliated with the umbrella organizations. We do not mean to imply that there is no need for local advisory councils representing local treatment agencies, but this is not what the umbrellas appear to be, since their boards of directors do not include all heads of local treatment agencies.

A second overlap, legislative in origin, was alluded to in an earlier section. All "health care" facilities must obtain a license from the Bureau of Health Facilities, with issuance contingent on approval by the county health planning people. On the other hand, the state Bureau of Alcohol and Drug Abuse has been given responsibility for certifying alcohol and drug treatment programs, personnel, and facilities. Given the less than full communication and cooperation between the state Bureau and county health people, especially in Clark County, a local treatment agency might well find itself in the midst of interagency bickering to the detriment of its clients—the very persons in whose behalf this whole structure was created. This problem has not fully surfaced yet, but the Bureau has not yet fully exercised its certifying powers.

A third overlap arises out of the continuing responsibility of the Mental Hygiene and Mental Retardation Division for NMHI and its Ward 10 alcohol abuse program. Thus far the overlap has not led to overt conflict; NMHI and the state Bureau seem to go pretty much their own ways. But conflict may occur in the future as the state or other local agencies plan for more comprehensive inpatient care analogous to that offered by NMHI. As mentioned at the beginning of this chapter, one of the continuing problems of alcoholism treatment throughout the country is its association with mental illness. Most authorities now believe that alcoholism is a separate entity, and that treatment is more successful if clients are not labeled as mental patients. In this context one can speculate that NMHI, with its image as a "mental hospital," may be driving away many alcoholics who would otherwise benefit from Ward 10's inpatient program. In any event, full and successful coordination of alcohol programs will be difficult so long as one of the main treatment programs functions totally outside the main delivery system.

Finally, there is an administrative problem. Although consolidation of drug and alcohol program coordination within a single agency makes for some bureaucratic efficiency, especially in a small state like Nevada, it must be recognized that, at the local level, separate agencies normally will handle alcohol and drug treatment. This reality was reinforced by the recent creation of separate drug and alcohol agencies at the highest federal level, and Tables 9.2 and 9.3 reveal the same division in practice at the Nevada level. Accordingly, any coordination effort must recognize that separation if it is to be efficient and successful. It is our opinion, for example, that the NASAC-DETRAP conflict in Northern Nevada reflects essentially drug-alcohol battle lines. Whether future coordination takes place at the umbrella level or within the state Bureau and its branch office, alcohol and drug program coordination probably should be kept as separate as possible up to the Bureau chief level.

In this connection the recent emphasis, in the Division of Rehabilitation's Facility Plan, on integrated planning and facilities for both drug and alcohol abuse needs further justification.⁶ There is no clear evidence that "future funding sources [in the Federal Government] will be for combined substance abuse services," particularly when drug and alcohol programs are being coordinated by newly created and separate federal institutes. But even if there were such a trend, most local treatment centers would not be likely to offer combined services for drug abusers and alcoholics, because of the differences between the two client populations.

Facility and Service Deficiencies

Alcohol Programs. Since need is a relative concept, it is not easy to say whether the treatment programs described for alcoholism are sufficient to meet the service needs of Nevada's 33,000 or so alcoholics. Clearly, the number served annually is much less than the number of alcoholics in the state. And, as is to be expected, the consensus of the large number of persons we interviewed during our field investigation was that current service capacity was insufficient. That consensus is confirmed by the almost total lack of certain types of services in major geographic regions.

For FY 1974 the Federal Government (NIAAA) spent approximately \$110 million on treatment and rehabilitation in the form of grants to states and direct grants to local treatment programs. Given the estimated number of alcoholics in the United States in 1970, that amounts to about \$31 a year per alcoholic. Similarly, California has an estimated 600,000 alcoholics, for whose treatment and rehabilitation the state spent approximately \$25 million during FY 1974, or about \$40 a year per alcoholic.⁷ All corresponding figures are much lower for Nevada. If our estimates of Nevada's alcoholic population are correct, by contrast the Federal Government will spend only about \$9 per alcoholic in Nevada during FY 1975 (\$285,000, comprising the full \$143,000 alcohol figure in Table 9.1 and \$142,000 for NIAAA grants in Table 9.3). Nevada state expenditures on treatment and rehabilitation of alcoholics—excluding the formula monies—are the \$415,000 for NMHI's Ward 10, \$66,000 for vocational rehabilitation (see Chap. 11), and about \$20,000 by the Las Vegas Mental Health Center; these combined amount to about \$15 per alcoholic, less than half the figure for California. In other words, it appears that Nevada is receiving (or at least spending) less than its fair share of federal funds for treatment of alcoholism, and is spending much less per alcoholic out of state funds than is neighboring California.

Although federal formula grants are made largely on the basis of gross population and not alcoholism rates, NIAAA also spends about \$60 million annually in the form of direct grants to local treatment agencies. If Nevada has about 0.8 percent of the country's alcoholic population, as Chap. 3 suggests, then it should be able to make a good case for claiming about \$480,000 of the federal community grant money—considerably more than the \$142,000 it is now receiving.

To this point we have been speaking of financial resources for the state as a whole. What about deficiencies within specific regions? First, we are convinced that

⁶ Nevada Division of Rehabilitation, *Rehabilitation Facility Plan, 1975-1980*, Carson City, Nevada, 1975.

⁷ See the *California State Plan for 1974/75*, published by the California Office of Alcohol Program Management. This report gives an estimated 1.2 million alcoholics; our Jellinek formulas yield about half as many. Only a small part of this \$25 million comes from federal formula grants.

the Las Vegas area has by far the largest concentration of alcoholics in the state, and yet it has fewer facilities and receives less in public expenditures than the Reno area—largely because of the location of NMHI. Although NMHI is open to anyone in the state, its long distance from Las Vegas undoubtedly deters many Clark County alcoholics and families desiring help. Even excluding NMHI expenditures, the public expenditures for alcohol abuse treatment in Reno are only slightly less than those for the Las Vegas area. We have already discussed the dearth of publicly supported alcohol programs in rural areas. Thus, from a regional standpoint, considering public expenditures in relation to the number of alcohol abusers in the region, it is clear that the Las Vegas area and rural regions are significantly less well funded than the Reno area.

Some specific facilities also are needed. Service personnel agree almost unanimously that the most important need in Nevada is for nonmedical detoxification facilities, especially in the Las Vegas area. The new four-bed EOB unit in Las Vegas will be the only publicly financed detoxification unit in the entire state. That is obviously insufficient for an area with over 15,000 alcoholics. The detoxification problem has become especially acute since drunkenness has been decriminalized by the same statutes, ironically, that created the new state alcohol program. The jails now cannot hold a drunk alcoholic beyond two days under a "disorderly" charge; after that there is no place to send the person. It has been alleged that this situation may have contributed to four deaths during this past year because of the victims' insufficiently treated withdrawal symptoms.⁸

Aside from the statewide deficiency in detoxification facilities, there is a deficiency of outpatient care capacity in the Reno area as compared with the relative predominance of halfway or live-in rehabilitation houses. Service system capacity of all types is deficient in the Las Vegas and rural areas. In Las Vegas, for example, halfway or live-in rehabilitation houses for alcohol abusers are in particularly short supply, and full inpatient care which is accessible to people who cannot afford private treatment is lacking (by which we do not mean medical hospital care, but rather alcohol abuse treatment analogous to that provided by NMHI).

Finally, there are staff training needs in the facilities that do exist. Most treatment personnel have little professional training other than AA experience or other personal experience as an alcoholic; important as these experiences may be, they do not necessarily equip a person to deal effectively with the variety of personal and social problems an alcoholic brings to the therapeutic setting. Furthermore, although AA techniques and philosophy have helped hundreds of thousands of alcoholics, many alcoholics spurn AA because they do not find its moral and religious appeal acceptable. The same holds for programs that are exclusively work programs; while many alcoholics need this type of rehabilitation experience, perhaps just as many do not.

There is wide agreement nationally within the alcoholism treatment community today that the key treatment-system concept is "comprehensiveness." A regional treatment system should have a centralized information and referral service, as well as a set of facilities (probably decentralized) that can be used as deemed appropriate to the needs of a particular alcoholic for detoxification, inpatient treatment, halfway

⁸ Interview with Dr. V. LoCicero, Nevada Mental Health Institute, Sparks, Nevada, November 1974; see also, for example, "Jail Cell Deaths," *Nevada State Journal*, July 21, 1974.

house or rehabilitation service, outpatient therapy or counseling, or some combination of these.

Drug Programs. Since the number of drug addicts is harder to estimate, it is difficult to do a financial analysis similar to that for alcoholism. Nonetheless, one can at least note that the 1975 NIDA budget includes about \$122 million for grants to community treatment agencies; if this amount were allocated on a total population basis (since we are not sure of the size of the drug addict population), Nevada would receive about \$400,000. The \$500,000 NIDA grant to SNDAC in Las Vegas therefore appears to satisfy the state of Nevada's fair share of federal funds (although areas of Nevada outside Las Vegas receive none of this money). On the other hand, the state itself has few expenditures for drug abuse other than the federal formula grant monies; in particular, it has no comprehensive treatment facility on a par with NMHI's Ward 10, which will accept drug abusers but which is primarily an alcoholism unit.* The lion's share of the drug abuse funds then, goes to the Las Vegas area even though Reno also has a significant drug abuse problem. And whatever drug abuse problems exist in rural Nevada are not attacked with any significant level of funding.

As with alcoholism, there are insufficient detoxification facilities for drug abusers. The shortage may have become especially acute with the recent cessation of Cedarbrook's detoxification operation in the Las Vegas area. Reno has no professionally staffed program for the hard-core addict. The drug abuse treatment system also has some other kinds of facility problems. Following up on the concept of a "comprehensive" treatment system with a full range of services that can be used as deemed appropriate to the needs of a particular drug abuser, we have noted earlier that there is no full inpatient care program analogous to the NMHI Ward 10 program but designed for drug abusers. Regarding halfway or live-in drug rehabilitation houses, it is of some concern that some of the live-in drug treatment facilities in the Las Vegas area are operating at less than capacity and a few have been embroiled in controversies about possible drug use. Our investigation was not exhaustive enough to discover what all the problems might be, but it is certainly true that before additional funds are spent in the Las Vegas area (and perhaps in the Reno area as well) there should be a careful analysis of existing facilities and services, and any modifications deemed necessary to render those services more effective should be made.

RECOMMENDATIONS

The problems described in the previous section call for concerted action on the part of state and local officials if the problems of alcohol and drug abuse are to be handled effectively in Nevada. It would be inappropriate for us to try to prescribe that action in detail, but we can provide an action agenda as a starting point. We believe our recommendations will be found consistent with the general goals and objectives specified in the 1975 *Nevada State Plan for Prevention, Treatment and Rehabilitation of Substance Abuse*.¹⁰

* At the time of our interviews only one inpatient was a drug abuser. He received the same treatment as the alcoholics, including watching films on alcoholism and listening to tapes aimed at alcoholics.

¹⁰ Nevada State Bureau of Alcohol and Drug Abuse, Carson City, Nevada, April 30, 1975.

In making these recommendations we recognize that organizational structures and service programs are still evolving in this area. Some of these developments are reflected in the 1975 state plan for substance abuse, in particular, the detailed planning for the proposed detoxification program for Washoe County sponsored by NASAC. But most of our recommendations, while consistent with goals in the state plan, are not yet implemented and not yet reflected in current detailed planning, especially those pertaining to Clark County—which encompasses between one-half and two-thirds of Nevada's alcohol and drug abusers. We are also concerned that the 1975 state plan reflects continued use of the words "Drug Abuse Council" in the SNDAC name (with no mention of alcohol), by its failure to propose realistic *detailed* plans for implementation of service program improvements for Clark County alcoholics, and by its use of underestimated alcoholism incidence rates, rates that are well below even the most conservative estimates available using NIAAA methods of estimation.

We recommend that comprehensive information systems be established for monitoring alcohol and drug abuse treatment programs, as well as alcohol and drug abuse rates. For alcohol abuse rates, it should be easy to tabulate cirrhosis deaths and beverage sales on a county-by-county basis and thus to make estimates of abuse rates like those in Chapter 3 to assist in regional planning. For drug abuse rates, the state should look into methods used by the National Institute on Drug Abuse. Information for monitoring service programs should be required from every local program receiving any federal or state funds, and should be requested from all others. IDARP may suffice for drug programs, particularly if supplemented by a simple form to obtain total funds by source, and staff members by background; a similar system should be implemented for alcohol programs. A prototype of such a system is available from NIAAA, and some funds are available to states that want to implement it.

The proper focus for these information systems is the state Bureau. In addition to these routine monitoring functions, the Bureau should also provide for periodic outcome evaluations of treated populations to determine the effectiveness of treatment.

A more streamlined organizational structure should be considered that eliminates overlapping jurisdictions on the one hand and recognizes separate spheres of activity on the other. A key feature of the arrangement we envision would be the creation of two councils, one for drugs and one for alcohol, in each of three regions: Clark County, Washoe County, and the remaining, predominantly rural, region of the state. Council membership would include all local treatment program directors (or perhaps a rotating subset) and selected local officials and leaders (e.g., representing the public, police, courts, schools, city councils, etc.). The council's main function would be to advise the state on plans for future services, current financial assistance, and certification. (Programs under certification review would not be represented during those deliberations.) In this way, some of the functions of the county Comprehensive Health Planning agency and the present umbrella organizations could be consolidated into a single structure. Representation on the councils would be much broader than it is in the present umbrella organizations. Certain functions of the current umbrella organizations, such as acting as a funnel for funds, seem unnecessary in a state the size of Nevada, which has a functioning state Bureau of Alcohol and Drug Abuse; hence those functions would be abolished. The separation of drug and alcohol councils recognizes the current realities both of local treatment organi-

zations and of federal financing agencies. It also should solve some of the local conflicts that have been observed since the creation of the NASAC and SNDAC umbrellas.

In recommending a modification to local umbrella agencies, we are not rejecting an umbrella concept of local coordination. On the contrary, the recommendation is intended to bring this concept into reality, since local coordination is clearly suffering at the present time (especially in Clark County). Moreover, we recognize that adequate permanent staffing for these councils may require continued state support (support similar to that provided for the current umbrella staff) and that Federal guidelines may make it desirable for continued direct service delivery by the councils (when local agencies are not adequate). Indeed, it is not suggested that the term "umbrella" need be eliminated, but only that the current structure is not fully meeting the objectives of local coordination.

A second major feature of the reorganization would be the transfer of administrative and budgetary control of the NMHI "Ward 10" to the Bureau of Alcohol and Drug Abuse. (We recognize that such a transfer would require legislative action.) We do not envision physically removing Ward 10 from the Nevada Mental Health Institute at the present time, although that might happen in the future. Instead, we would give administrative and budgetary control of the alcohol and drug abuse treatment program to the alcohol and drug abuse agency rather than to the Mental Hygiene and Mental Retardation Agency, which has different priorities. Auxiliary services and facilities for Ward 10 patients, such as medical care, recreational facilities, and "industrial therapy" (jobs), could be obtained from the other segments of the NMHI as they are now. The bookkeeping system at NMHI is such that it would not be too difficult to arrange for an interagency transfer of funds to cover those services and the use of facilities.

We are not necessarily arguing that direct clinical supervision of Ward 10 be placed at the Bureau of Alcohol and Drug Abuse, since its present structure may not include sufficient professional staff for such responsibilities. Rather, we are recommending an administrative and budgetary realignment, since we do not see how full program planning and coordination is possible with the current fragmentation of programs across different divisions. Ward 10, the largest treatment program for alcohol abuse in the state, is now effectively separated from the Bureau of Alcohol and Drug Abuse.

We recommend the creation of a comprehensive alcoholism treatment program for the Las Vegas area. Although a number of new or expanded programs are needed for alcoholism treatment throughout the state, the most pressing needs are undoubtedly in the Las Vegas area. Federal funds may be available to help fund such a program. By a "comprehensive" program we mean the provision of several types of care appropriate for different types of clients. The following services should be included: a nonmedical detoxification unit and holding center that can handle up to 10 clients; a short-term (e.g., 30-day) full inpatient treatment facility with perhaps 20 to 40 beds (similar to the NMHI Ward 10 program and accessible to those who cannot afford private treatment); rehabilitation or halfway houses for longer-term recovery with at least 20 to 40 beds; and a full range of outpatient services including individual and group therapy and antabuse treatment. The staff should include at least three full-time therapists with training in therapeutic counseling at the master's degree level. Some of these services might be arranged by expanding or working with existing facilities and programs.

Both drug and alcohol detoxification services should be provided throughout the state. The present lack of these essential services has been documented earlier.

A few small halfway or live-in rehabilitation houses for alcohol and drug abusers should be established throughout rural Nevada, with provision for outpatient services at those same facilities. As with many other services, rural Nevada is currently lacking in alcohol and drug abuse treatment programs. Full inpatient treatment programs are probably not practical in rural Nevada because of sparse populations, difficulty in obtaining qualified staff, and hence the high cost per person served; full inpatient services can probably be more adequately provided to rural alcohol and drug abusers through short-term residence in Reno (NMHI) or the Las Vegas treatment center we recommended above. However, it does appear feasible and desirable to provide the less intense live-in rehabilitation house and outpatient services in small programs directly in the larger rural communities. That is, some of the larger rural communities appear to have sufficient numbers of people needing halfway or rehabilitation house and outpatient treatment so that small programs in those communities can be fully utilized and be economically feasible.

We recommend creation of a short-term, professionally staffed, full inpatient treatment program for drug abusers in Nevada, analogous to the NMHI Ward 10 program, which is designed primarily for alcohol abusers. This would fill a notable major gap in the service system. Another important issue in the drug abuse treatment area is the existing delivery system in the Las Vegas area. Before any other new expansion is contemplated (other than detoxification), there must be a careful analysis of the reasons for underutilization of some existing facilities (those reasons do not appear to include lack of need for the services) and a determination of the reasons for controversy over alleged drug use in some halfway houses in the Las Vegas area.

Finally, we reiterate the need for direction and coordination of services, and refer the reader to Chap. 4 for our recommendations for the creation of Regional Direction Centers.

An alcohol and drug abuse facility plan prepared in 1974 for the Nevada Division of Rehabilitation¹¹ indicated no need for additional treatment facilities prior to 1980 with the exception of nonhospital detoxification facilities. Although we have recommended that services be expanded, our recommendations are not necessarily inconsistent with that facility plan. The reason is that while hospital and intermediate care facilities exist in the state, as do facilities that could be used for outpatient treatment, alcohol and drug abuse treatment services are not now being provided in most of those existing facilities.

¹¹ *Rehabilitation Facility Plan, 1975-1980.*

Chapter 10

RESIDENTIAL MENTAL HEALTH AND MENTAL RETARDATION SERVICES

INTRODUCTION

Residential programs required to meet the diverse needs of mentally handicapped people range from full inpatient care facilities, through less service-intensive intermediate care facilities, to semi-independent residential living programs that offer minimal supervision and assistance. Because the residential service needs of people with mental health disorders are vastly different from those of people with mental retardation, the needs of these two groups of people are discussed separately in this chapter.

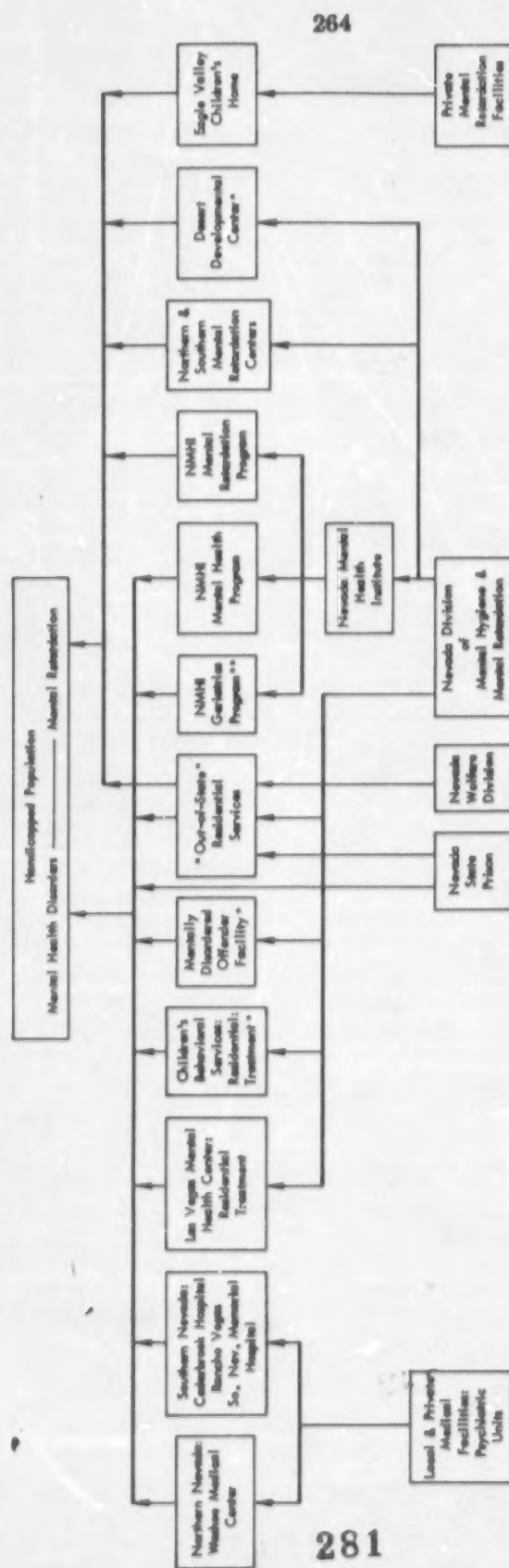
We focus in this chapter on *residential service* programs intended to provide more than the supervised *residential living* discussed later in Chap. 13. For people with mental health problems, the residential service programs discussed here include: the Nevada Mental Health Institute's (NMHI) mental health and geriatrics programs, the Las Vegas Mental Health Center's residential treatment program; the new Children's Behavioral Services residential treatment program; Cedarbrook Hospital; Rancho Vegas Nursing Center; Southern Nevada Memorial Hospital; Washoe Medical Center; the Nevada State Prison; the new Mentally Disordered Offender Facility; the Veterans Administration Hospital program discussed in Chap. 8; and various out-of-state residential treatment programs where Nevadans are sent when appropriate in-state services are not available for them. For mentally retarded people, the residential service programs include the NMHI's mental retardation program, the Eagle Valley Children's Home, the Northern and Southern Nevada Mental Retardation Centers, the new Desert Developmental Center, and out-of-state residential treatment programs where a few mentally retarded youth with mental health disorders are sent.

In Chap. 9 we discussed residential service and residential living programs for alcohol and drug abusers, including those at NMHI. In Chap. 12 we discuss medical facilities in Nevada that do not have special programs for provision of mental health or mental retardation services. Chapter 13 concentrates on programs that provide supervised residential living for people who are unable to live with their own families or fully independently in the community, but that are not intended to and do not provide any substantial mental health or mental retardation services.

Figure 10.1 depicts the organization of the residential mental health and mental retardation service system discussed in this chapter. The system has three major sectors: public facilities, private facilities, and out-of-state facilities where some Nevadans are sent when appropriate in-state services do not exist.

Table 10.1 is a summary of the estimated number of people served, staff, and expenditures for these residential service programs in FY 1974.

For Nevadans with mental health disorders, approximately \$6 million was spent for residential care and treatment in FY 1974. Note that in terms of daily average bed-capacity filled, the NMHI was the largest (160), followed by local and private



* Not yet in operation in July 1975.

** To be established in 1975.

Fig. 10.1—Organization of major residential mental health and mental retardation services in Nevada

Table 10.1

**SUMMARY OF MAJOR RESIDENTIAL MENTAL HEALTH AND MENTAL
RETARDATION SERVICES IN NEVADA, FY 1974**

Program ^a	Estimated Number Served		Estimated Total Staff (Service and Support)	Estimated Annual Expenditures
	Per Day	Service Episodes Annually ^b		
Mental Health Services				
NMHI: Mental Health Program	80	750	100	\$1,200,000
NMHI: Geriatrics Programs	80	<120	80	950,000
Las Vegas Mental Health Center: residential treatment	30	650	46	550,000
Children's Behavioral Services: residential treatment ^c	0	0	0	0
Local and private general hos- pitals: psychiatric units	64	1776	100 ^d	2,900,000 ^d
Nevada State Prison	12	<24	6	100,000
Mentally Disordered Offender Facility ^c	0	0	0	0
Veteran's Administration Hospital ^c	0	0	0	0
Out-of-state residential services	20	<25	NA	200,000
Total, mental health	286	<3345	332	\$6,000,000
Mental Retardation Services				
NMHI: Mental Retardation Program	140	<160	130	\$1,600,000
Desert Development Center ^c	0	0	0	0
Eagle Valley Children's Home	10	<15	7	40,000
Mental Retardation Centers	54	75	46	650,000
Out-of-state residential services	4	—	NA	40,000
Total, mental retardation	208	<250	183	\$2,330,000

NOTE: NA = not available.

^aSee text of this chapter for sources of data. Total NMHI staff were split among the different programs in proportion to program expenditures.

^bSince a person may be a resident at more than one facility in a year, or be readmitted to the same facility after an earlier discharge the same year, the number of people served will be smaller than the number of resident service episodes.

^cNot in operation in FY 1974.

^dData on total staff and actual expenditures were not available for all facilities. We assume an average of \$325 per day including hospital, drug, physician, and other fees, and we assume the same average total staff level as that existing in the Las Vegas Mental Health Center inpatient units.

general medical facilities with psychiatric units (64), and the Las Vegas Mental Health Center (30). However, in terms of the number of service episodes annually, the largest residential service program by far is that provided by local and private medical facilities (1776), followed by NMHI (up to 870) and the Las Vegas Mental Health Center's residential program (650). In FY 1974 the Nevada state service system (i.e., all except local and private medical facilities with psychiatric units) accounted for about 78 percent of the utilized bed-capacity, 47 percent of the annual service episodes, 70 percent of the staff, and 52 percent of the expenditures. Thus, the state system is significantly less expensive per bed-year, but incurs about the same cost per service-episode since the service-episodes are longer than they are for local and private medical facilities. Such direct comparisons are difficult to interpret, however, because the types and severity of the mental disorders seen in the two sectors were quite different in FY 1974. Since FY 1974, the residential mental health service system has been undergoing major changes: the geriatrics program at NMHI has been greatly reduced and the staff transferred to the NMHI neuropsychiatric program, which has decreased the median patient-stay for discharged patients to 17 days in 1975; a new Mentally Disordered Offenders Facility has been constructed (bed-capacity 32); two Children's Behavioral Service residential treatment facilities are being created (each with a planned bed-capacity of 16); and the Rancho Vegas Nursing Center has planned to open a long-term psychiatric care section (bed-capacity 39). The probable net effect of these changes will be an increase in the utilized bed-capacity in Nevada of about 11. The prime reason the utilized bed-capacity will not increase substantially in spite of the new construction is that the number of residents at NMHI is being substantially reduced so that those remaining can receive better mental health services (the staff has not been reduced) and be served in NMHI's better buildings.

For mentally retarded Nevadans, about \$2.3 million was spent for residential services in FY 1974. The Nevada state service system (which includes all but the Eagle Valley private facility) accounted for over 95 percent of the people served, staff, and expenditures.

Since FY 1974, the residential mental retardation service system has begun major change: a new Desert Developmental Center is being constructed in Las Vegas (bed-capacity 56); when it opens, the NMHI mentally retarded resident population will be cut to less than half of the FY 1974 level. The plan is to reduce the number of residents at NMHI without reducing the staff, so that those remaining can receive better services and can be served in improved facilities. With these and other changes, the NMHI may be able to achieve accreditation as a mental retardation facility.

We note that merely to maintain the 1974 quantity of service per capita in 1985, the bed-capacity and annual budget (in constant value dollars) of the residential mental health service system would have to be increased from 286 to 380 beds and from \$6.0 to \$8.0 million (see Chap. 3 for population projections). To maintain the 1974 quantity of residential service per capita for mentally retarded Nevadans, the service system's bed-capacity would have to increase from 208 to 276 and the annual budget from \$2.3 to \$3.7 million.

The next sections of this chapter discuss the above-mentioned residential service programs and their deficiencies. We then present recommendations for improvement. Mental health services are covered first, followed by separate sections on mental retardation services.

NEVADA MENTAL HEALTH INSTITUTE

Located in Sparks just outside Reno, the NMHI is a 412-bed facility serving people with mental health, mental retardation, and alcohol and drug abuse problems.¹ It has been undergoing tremendous change. The total number of residents with all types of mental handicaps has declined from about 550 in 1966 (including about 150 mentally retarded residents, about 20 alcohol and drug abusers, and about 380 with mental health disorders), to an average of 326 in FY 1974, and finally to about 220 in July 1975 (including about 110 mentally retarded residents, about 16 alcohol and drug abusers, and about 94 adults with mental health disorders). Most of this massive decline occurred as the mental health program at the Institute shifted from chronic patient care toward short-term acute patient service.

The NMHI served a total of 716 clients in the last six months of 1973.² Given the July 1975 census of about 220 people, of whom about half are long-term mentally retarded residents and about 50 are short-term neuropsychiatric patients whose median stay is 17 days, we estimate that the FY 1976 number of patient-stays may be as high as 1500 on an annualized basis. Some of those patient-stays, however, will be repeat admissions in the same year. In January 1976, 49 percent of the NMHI neuropsychiatric admissions were readmissions of clients who had been previously served. In that same month, the average daily number of inpatients was 227; the average daily census in January 1976 was 270, including inpatients, day care and partial hospitalization patients, outpatients, those on home visits, and those who were "AWOL".

In FY 1974 the NMHI had 867 additions to its inpatient population. This amounted to 157 per 100,000 civilian resident population in the state; the national average was 208 and 14 states had a lower number of additions per 100,000 population than did Nevada. In terms of inpatients at the end of FY 1974, the NMHI had 59 per 100,000 civilian resident population; the national average was 103, and 15 states had a lower number of inpatients per 100,000 population than did Nevada.³

In FY 1973, 40 percent of the admissions to the NMHI were readmissions of previous patients. In that year, the geographic distribution of all admissions was: Clark County, 56 percent of the state's population and 18 percent of NMHI admissions; Washoe County, 24 percent of the state's population and 61 percent of the admissions; and all other counties combined, 20 percent of the state's population and 21 percent of the admissions.

In FY 1974 there were 335.5 authorized staff positions at the NMHI. That figure remains almost unchanged. Despite nonaccreditation of the NMHI partly because of staff deficiencies in the mental retardation area, and despite the serious deficiencies in psychological services staffing in the neuropsychiatric area pointed out by the

¹ Information in this section was obtained from NMHI statistical records; interviews with Dr. V. LoCicero, Medical Director, and various other staff members between April 1974 and August 1975; Governor M. O'Callaghan, *The Executive Budget, Fiscal Years 1975-76 and 1976-77*, State of Nevada, Carson City, Nevada, January 20, 1975 (hereinafter cited as *Executive Budget*); and a letter from T. Piepmeyer, NMHI, Sparks, Nevada, to J. Kakalik, The Rand Corporation, Santa Monica, California, February 27, 1976.

² Charles R. Dickson, "Division of Mental Hygiene and Mental Retardation Biannual Report for July-December 1973," in a memorandum to Roger Trounaday, Department of Human Resources, Carson City, Nevada, February 5, 1974.

³ Nessa Meyer, *Provisional Patient Movement and Administrative Data—State and County Mental Hospital Inpatient Services—July 1, 1973-June 30, 1974*, National Institute of Mental Health, Statistical Note 114, Department of Health, Education, and Welfare, Rockville, Maryland, April 1975.

survey team of the Joint Commission on Accreditation of Hospitals, the 1975 session of the state legislature approved only one new service position for the Institute.⁴

The deficiencies in the physical facilities at the NMHI are numerous and were well documented in a series of three reports in 1974.⁵ The Nevada Division of Mental Hygiene and Mental Retardation described the Institute's facilities to the state legislature in 1975 in the following terms:

Currently, the Nevada Mental Health Institute physical plant is not geared toward positive images and structures for mental health. As a cross between the county jail and the poor farm, the Institute facilities have been physically built up over the years to provide custodial care for the mentally ill who are excluded from life in their communities, their families and friends. The current residential facilities, in their present form and condition, are not fit as living quarters for persons expected to feel and act according to positive social conventions. Opportunities for productive, healthy activities during the day are minimal, often replaced by sleeping, aimlessness, disturbances, and occasionally by assignments in the laundry and food service. . . .⁶

In response to a request by the Division of Mental Hygiene and Mental Retardation to remedy some of those deficiencies, the Nevada Public Works Board and the 1975 session of the state legislature approved several capital improvement projects:

- A *Desert Developmental Center* in Las Vegas, described elsewhere in this chapter, providing a range of services to mentally retarded people, some of whom are now residents of the NMHI (total funds \$2,494,800).
- An *NMHI Site Development* project to provide landscaping, security lights, parking, and walkways (total funds \$675,000).
- *Improvements to 6 mental health and mental retardation buildings, NMHI*, mostly for interior remodeling and refurnishing (total funds \$540,900).
- A *Day Activities Facility, NMHI*, to provide a central activity area off the living unit for normal day activities (total funds \$391,500).
- An *Inpatient Residential Facility, NMHI*, to provide three new buildings to serve as living units for 16 inpatients each (total funds \$1,335,600).
- *Renovation of Building No. 11, NMHI*, to provide a transitional living unit for about 16 persons not ready to assume complete independent living, but who are beyond the need for a highly supervised living environment (total funds \$135,900).⁷

Just over \$3 million, then, will be spent directly at the present NMHI site. The result will be a substantial improvement in some of the existing facilities used by

⁴ A new geneticist position was approved, and a previously authorized slot for an Institute Director was also funded. Information provided by H. Clemons, Management Analyst, Division of Mental Hygiene and Mental Retardation, Reno, Nevada, June 20, 1975. The Joint Commission on Accreditation of Hospitals survey is discussed in detail later in this chapter, and in App. B.

⁵ F. Wittman et al., *Report on Planning and Utilization of Nevada Mental Health Institute Facilities, NMHI Environmental Assessment According to Division Goals and Objectives, and Long Range Planning Report for Development of the Nevada Mental Health Institute Facilities and Grounds*, Center for Environmental Change, Berkeley, California, 1974.

⁶ Nevada Division of Mental Hygiene and Mental Retardation, *Nevada Mental Health Institute Capital Improvements*, report prepared for presentation to the Nevada Legislature, February 1975.

⁷ *Ibid.*, and information provided by H. Clemons, Management Analyst, DMHMR, Reno, Nevada, June 19, 1975.

neuropsychiatric and mentally retarded residents, and substantial new facilities for neuropsychiatric patients. As detailed later, the Division's intention is to construct two new facilities for mentally retarded people elsewhere (the already-approved Desert Developmental Center in Las Vegas is one of these two).

In FY 1974, NMHI's total expenditures were \$4,557,000. Beginning in June 1974, the established rates for inpatient hospitalization at the NMHI, reflecting the actual costs per patient-day, were: \$40.70 per day for neuropsychiatric service (\$14,856 per patient year); \$31.17 per day for mental retardation service (\$11,377 per patient year); and \$32.37 per day for geriatric service (\$11,815 per patient year).^a Since June 1974, the number of neuropsychiatric and geriatric patients has been declining substantially while their staffs have been retained and combined, resulting in a substantial and continuing rise in costs per neuropsychiatric patient-day.

The four very different service programs within the Institute (mental health, geriatric, mental retardation, and alcohol and drug abuse) are separately described below, except for the alcohol and drug abuse program, which was described in Chap. 9.

NEVADA MENTAL HEALTH INSTITUTE: MENTAL HEALTH PROGRAM

The massive decline in the number of NMHI residents with mental health disorders, from about 380 in 1966 to less than 100 in the fall of 1975, was due primarily to the discharge of long-term inpatients with mental health disorders—people who typically were classified by the Institute in the mid-1960s as having chronic organic brain syndrome or schizophrenic reactions.^b Some had been in the Institute for 20 to 30 years. Thus, in the past ten years the neuropsychiatric section of the Institute has shifted its primary emphasis from chronic residential care to primarily short-term treatment. The median length of stay for neuropsychiatric patients discharged from the Institute in 1975 was only 17 days (down from 109 days as recently as FY 1973). That is, half of those people discharged in 1975 stayed 17 days or less. The average length of stay in 1975 was 30 days. The NMHI residential program, however, does continue to serve a few longer-term neuropsychiatric clients. Not counting the 33 geriatric clients the NMHI plans to discharge, one neuropsychiatric client had been in NMHI over a year as of February 2, 1976; seven other clients had been in NMHI 6 to 12 months; and 13 others had been there 3 to 6 months as of February 2, 1976. In terms of length of stay, at least, the Institute is now primarily functioning much the same as the inpatient units at Washoe Medical Center, Southern Nevada Memorial Hospital, and the Las Vegas Mental Health Center. The Institute is not functioning primarily as a place for treatment of patients who need longer term care than that typically provided by those three community-based facilities. For discussion of the NMHI's plans for discharge of the 33

^a Information provided by T. M. Reynolds, Business Manager, NMHI, Sparks, Nevada, May 13, 1974.

^b Information in this section was obtained from NMHI statistical records; several interviews between April 1974 and August 1975 with the Institute's Medical Director, Dr. V. LoCicero; interviews in mid-1974 with numerous Institute staff members including the psychiatrist, nurse, social worker, and most mental health technicians on each neuropsychiatric ward; and individual interviews in July 1974 by a Rand consultant psychiatrist with about 20 percent of the residents on the neuropsychiatric wards, NMHI, Sparks, Nevada.

geriatric patients, see a later section of this chapter on services to NMHI geriatric residents.

While the resident neuropsychiatric population at the Institute has been declining, the size of the staff has not; consequently the remaining patients can receive significantly better services. Also, after completion of the facility improvements for the Institute approved by the 1975 Nevada Legislature, less than half the remaining neuropsychiatric patients will be housed in facilities that were used in 1974. With the discharge of long-term neuropsychiatric and geriatric patients, with the building of the Desert Developmental Center and the planned transfer of half the mentally retarded Institute residents to it, with the completion of the new Mentally Disordered Offender Facility, and with the new buildings being constructed on the grounds of the Institute, we note that the majority of the Institute's wards used in 1974 will be vacated. The Nevada Legislature, in effect and in piecemeal fashion, has approved reconstruction of more than half the Institute, in a partially decentralized manner, in some cases in the form of facilities with different names. Improved facilities for residential treatment of mentally handicapped Nevadans will result, and the change also means that some of the old and admittedly deficient facilities could be used temporarily to expand the currently inadequate capacity of the mental health service system if new staff were approved for them (see the recommendations sections of this chapter for areas of needed service expansion).

The NMHI admission procedure involves an officer of the day, who may or may not be a psychiatrist and who screens all referrals in deciding on admissions. Subsequent to admission, the neuropsychiatric patient is assigned to one of the wards and an intake interview is conducted by the ward psychiatrist. In addition to these two initial interviews by Institute personnel, a psychiatrist from the Reno Mental Health Center conducted a third preadmission interview at the Institute for applicants from Washoe County in 1974. This Mental Health Center screening recommended admission to the Institute for 90 percent of those screened. Most of the 10 percent screened out were said to be alcoholics; because we suspect they would not have been admitted by the Institute's officer of the day anyway, the added screening at the Institute by the Reno Mental Health Center seemed to be a superfluous and largely inefficient use of scarce professional talent. Moreover, information gathered in the interview by the RMHC psychiatrist was not passed on to the Institute. The screening form given to the Institute by RMHC gave only three lines of information: name, age, sex, and attestation by the RMHC psychiatrist that he believes the patient is unwilling or unable to be served outside the Institute at the present time. An Institute psychiatrist opined that the RMHC preadmission screening is "meaningless" and "so superficial that it is a waste of time," but that it did increase RMHC caseload statistics. The Reno MHC preadmission screening of NMHI clients has been terminated.

Statements by the RMHC psychiatrist who did preadmission screening at the Institute, concerning the total lack of day treatment programs, highlighted the problem of the lack of a range of levels of mental health care in the Reno area. He said: "I don't want to take a chance on those patients on an outpatient basis;" and therefore "I put them in the hospital [the Nevada Mental Health Institute] when

they really need day care."¹⁰ In sum, they are placed in a residential institution when in his professional opinion they need a more appropriate type of treatment which, if it were available, almost certainly would be less expensive.

This issue of acceptance of patients at the Institute who really need another type of care was also mentioned by one of the Institute's psychiatrists, who said that he admitted as "overnight cases" one-third of all the patients he screened because no other appropriate community facilities were available to meet their needs. He indicated that a major need exists for very-short-term or overnight residential treatment and day-care facilities in the state. He also said he has sent people to the Nevada State Prison because the Institute had no locked facilities in which to keep them. (This situation has been partially remedied since our interviews by a court-ordered evacuation of noncriminals from the prison psychiatric unit (discussed elsewhere in this chapter), by the temporary creation of a secure unit at the Institute, and by the Mentally Disordered Offender Facility now under construction.)

The daytime staff on each of the three NMHI neuropsychiatric units in mid-1974 typically was composed of one psychiatrist, one psychiatric nurse, one social worker, and four or five mental health technicians who are assigned as "primary therapists" to patients. There were only 1½ full-time-equivalent psychologists in the entire NMHI, and they provided only very minimal counseling and consultative psychological services to the neuropsychiatric units.

In contrast, San Francisco's outstanding Mt. Zion Hospital (with 18 inpatients, 8 outpatients, and 20 partial care patients in late 1975) had 8 psychiatrists, 3 psychologists, 3 psychiatric social workers, 3 occupational therapists, 4 part-time activities specialists, and 18 nurses. The staff also includes private psychiatrists who come to treat their patients.¹¹ The patient's day is individually programmed with services from early morning until after dark. Admittedly, this level of services is exceptional. It is an order of magnitude more intense than that provided at the NMHI or anywhere else in Nevada. We are not saying Nevada services should all be upgraded to that expensive standard, but it does indicate what one of the better programs is providing.

One possible problem area we observed concerned the planning of daily activities for the NMHI neuropsychiatric units. They apparently are often planned on a catch-as-catch-can basis by the unit's nurse and mental health technicians rather than by the unit's psychiatrist or by a team of professionals. There also appeared to be little supervision or control of the mental health technicians by the psychiatrists. Upon our inquiring into this situation, the mental health technicians told us that, typically, any supervisory time provided by a unit's psychiatrist, psychiatric nurse, or social worker that was therapy-related usually was for crises and not for regular psychotherapy. There reportedly is little one-to-one consulting on individual patients between psychiatrists and technicians. Two of the psychiatrists told us that the nursing department is quite independent, so much so that the nurses threatened to go on strike in response to the doctors' efforts in early 1974 to obtain more control of activities on the units. The nursing department hires and fires the mental health technicians; the physicians' opinions on personnel are obtained but not always followed.

¹⁰ Interview with Dr. Hamilton, Reno Mental Health Center, Transition Unit, Sparks, Nevada, July 2, 1974.

¹¹ Information provided by Dr. R. Rubenstein, Mt. Zion Hospital, San Francisco, California, July 1974.

As an example of daily activities for NMHI residents with mental health problems, one unit typically had mental health technicians talking with various patients on a one-to-one basis for a total of 2 to 3 hours per day, plus group therapy for about 1½ hours per day. Approximately half the patients were said to meet with their primary therapist (mental health technician) on any given day. Many of the patients worked in various jobs at the hospital, e.g., in the kitchen or laundry, in what is called "industrial therapy." Arts and crafts and recreational facilities were available. Usually, one organized recreational activity was scheduled for patients each day. By Institute policy, patient participation in activities was voluntary.

Several patients told us it was difficult to get to see a psychiatrist in the three neuropsychiatric units at the NMHI. On investigation it appeared that less than half of the three psychiatrists' time is available for patient therapy. One unit's psychiatrist had 11 to 15 hours per week for direct patient contact. Another said his typical week consisted of 35 day-shift hours, plus some night and weekend coverage. Of the 35 hours, he said he spent about 8 hours as officer of the day for admissions, about 10 hours in committee meetings that were not directly service-related, about 5 hours on records, and the remaining 12 hours for direct patient therapy. (All three psychiatrists mentioned a heavy time requirement for meetings, but the Director of the NMHI indicates, for example, that the March 1976 schedule has only 6½ hours of meetings all the psychiatrists are expected to attend). The third psychiatrist reported having 15 hours per week for direct contact with patients to provide therapy.

The psychiatrist on each unit typically spends 11 to 15 hours per week in direct therapeutic contact with patients. Not all patients meet individually with the psychiatrist for treatment even once a week. One psychiatrist conducts a group psychodrama session on his unit for an hour a week. Given this limited available direct contact time between psychiatrist and patient, other staff members must carry a heavy responsibility for patient care. On the average, each unit's psychiatrist has on the order of only one-half hour per week in direct contact time, exclusive of record keeping, per patient in his unit. Since the median length of stay at NMHI is only a little over two weeks, it is obvious that the psychiatrists can spend very little time with a typical patient during the entire stay at NMHI.

The social worker on the unit typically consults with mental health technicians, meets with patients' families if they come in, writes a social history on each patient, attends meetings, and does some pre-discharge work (e.g., with respect to financial assistance for medication after discharge), but provides little direct treatment. One social worker commented that all the records and forms required would have tremendous meaning in the Institute "did the therapy part." It is clear that most staff members on the neuropsychiatric units, from the psychiatrists to the technicians, spend less than half of their work time in actual direct treatment of patients.

One of the most serious problems with NMHI mental health services is the low level of skills of the mental health technicians, who must carry much of the responsibility for patient treatment at the Institute. Most are not skilled enough to perform that work adequately. In practice, consequently, the primary mode of therapy for most mental health patients at the Institute appears to be chemotherapy. Although psychopharmacological intervention has become increasingly useful, it is primarily useful as an adjunct to other kinds of treatment (e.g., psychotherapy), which it may facilitate *but does not replace*.

One psychiatrist in the Division of Mental Hygiene and Mental Retardation who was in a position to know about neuropsychiatric services at the Institute indicated that, in his professional opinion, "There is not much effective psychotherapy on the wards. . . The techs [mental health technicians] have no real training. . . most of their psychotherapy is just 'chit-chatting.'"¹²

One NMHI psychiatrist indicated that his unit's staff is not capable of carrying out detailed psychiatric treatment orders, and therefore he does not write them.

Another indicated that "a few of the MHTs can work well with the patients . . . but most are not well trained." Yet another said that drugs must be used extensively because the Institute does not have staff to provide "good psychotherapy." One talked of only "covering up" (i.e., reducing symptoms of the mental disorder) but not "uncovering" and systematically addressing patients' problems.

Another NMHI professional likened the present psychotherapy at the Institute to giving a drowning man a tube of air at the bottom of a swimming pool instead of helping him out of the water.

Mental health technicians reportedly spend a good deal of their time doing patient escort, housekeeping, phone-answering, and similar nontherapeutic work. Most technicians we interviewed said less than half their time was available to provide therapy to patients.

The patients interviewed by one of Rand's consultant psychiatrists confirmed that patient treatment occupied less than half of the mental health technicians' time. On one unit, none of the four patients we interviewed even knew which technician was assigned as his or her primary therapist, although patients on the other two units did know. The patients on that one unit were not told who their primary therapist was because the nurse in charge said she did not want the staff to become "too possessive" with respect to individual patients.

Some of the mental health technicians we interviewed who were assigned as primary therapists did not know their patients well. For example, they might not know what medication the patient was on, and its effects and side-effects for which to be alert. The supervising nurse on one of the three units did not know most of the patients and their problems when we questioned her; the same was not true of the other two units.

One favorable aspect of the Institute is that the neuropsychiatric patients interviewed generally liked the staff members and believed they were trying to help. None had any complaints of sadism by staff members or inadequate protection, by the staff, of one patient from another.

Turnover of the NMHI's mental health technicians, the most prevalent type of direct service employee, was 48 percent in FY 1974 for the neuropsychiatric program and about the same for the mental retardation program. Of those who quit, 40 percent do so after having worked six months or less. The employee turnover rate for the Institute as a whole was 34 percent in FY 1974.¹³ Turnover rates were 10 percent for all Nevada state employees, 30 percent for St. Mary's Hospital, 29 percent for the Nevada mining industry, and 48 percent for the Nevada manufacturing industry. In 1975, the turnover rate of mental health technicians was reduced

¹² Anonymity was assured to this and several other interviewees.

¹³ H. Robert Quilitch, "Employee Turnover and Sick Time," NMHI, Memorandum to All Interested Persons, Sparks, Nevada, December 3, 1974.

to 22 percent for the neuropsychiatric and geriatric programs. Thus, while the turnover rate of mental health technicians has been high in an absolute sense, it is not clear how hard it would be to significantly and permanently reduce the rate. We also note that if salary and hiring qualifications were upgraded for some types of mental health technicians, past turnover rates probably would not be a reliable predictor of turnover among the more highly skilled mental health technicians (see Chap. 8 for a discussion of the training and use of more highly skilled technicians).

The Mental Health Technician I job class definitions and minimum qualifications are basically a high school education (or substitute work experience) plus one year of work experience (or one year of college as a substitute). The Mental Health Technician II, III, and IV job classes *officially* require additional work experience (or substitute years of college) plus *substantial amounts of training* of the employee in a course curriculum sponsored by the Division of Mental Hygiene and Mental Retardation. For illustration, the following are official state job class definitions and minimum education and experience qualifications for Mental Health Technicians I, IV:

- *Mental Health Technician I*

Definition of the class:

Under direct supervision, assists in the care of the mentally ill patients or mentally retarded residents at an entrance level; receives classroom and on-the-job instruction in patient care; maintains living quarters of patients; assists in the care and habilitation of the mentally retarded by applying beginning habilitative techniques as obtained in the classroom and on-the-job instruction; does related work as required.

Minimum Education and Experience:

Graduation from high school or equivalent education, and one year of full time paid experience. (Two years of employment in an institution or agency providing care, treatment, and/or training for the mentally ill or mentally retarded may be substituted for the high school education.) (Appropriate college training may be substituted for the work experience on a year for year basis.) (During the first 12 months of employment the employee will be expected to participate in a 150 hour training course. An additional 150 hour course will be offered to enable the employee to qualify for Mental Health Technician II.)

- *Mental Health Technician IV*

Definition of the class:

Under supervision, performs the most responsible subprofessional tasks in the care and treatment of mentally ill or mentally retarded patients; supervises patient activities; and does related work as required.

Minimum Education and Experience:

Graduation from high school or equivalent education and four years of full time paid work experience, three years of which must have been as a Mental Health Technician under professional supervision in the care and treatment of the mentally ill or mentally retarded plus completion of a 900 hour course curriculum sponsored by the Division of Mental Hygiene and Mental Retardation. (Two additional years of employment in an institution or agency providing care, treatment and/or training for the mentally ill or mentally retarded may be substituted for high school education) or appropriate college training may be substituted for all but one year of the required work experience on a year for year basis provided the candidate qualifies on testing equivalent to Mental Health Technician I, II, III and IV written examinations. Each candidate must have at least

one year of experience in the care and treatment of the mentally ill or mentally retarded in Nevada State service. (Employees qualifying with college training for the Mental Health Technician III must have met a special 300 hour curriculum requirement prior to promotion to this level during their employment as a Mental Health Technician III and employees qualifying with college training for Mental Health Technician II must have completed the 600 hour course curriculum sponsored by the Division of Mental Health and Mental Retardation prior to promotion to this level during their employment as a Mental Health Technician II and III.)¹⁴

Note that one of the official stated requirements of a Mental Health Technician I is participation in a 150-hour training course in the first year of employment. A 300-hour "course curriculum" sponsored by DMHMR or "appropriate college training" or a "commensurate education program" completed elsewhere are officially required for an MHT II job, and officially an MHT IV must have at least 300 hours and up to 900 hours of training depending on the person's background. So much for what training is officially supposed to be provided. *In practice*, we learned in our interviews that in mid-1974 there was no formalized training program for all mental health technicians working in the neuropsychiatric section of the NMHI. We were told that a 40-hour staff training program was due to start soon, but that is a far cry from what is needed and what is theoretically supposed to be provided, based on the descriptions of the minimum job qualifications. While we have no doubt that the technicians learn by doing on the job, and we have no doubt that other employees informally offer suggestions that increase job skills, this haphazard approach and inadequate formal training is a major problem at the Institute. We were also told in our interviews that the almost totally untrained Mental Health Technicians I, II, and III, who need only a high school education, all perform much the same duties on the neuropsychiatric units and that each level of technician can and does serve as what the unit staffs called the "primary psychotherapist" for mentally ill patients. While each unit has a psychiatrist, none has a full-time psychologist to help provide therapy. According to unit staff members, some patients in practice in mid-1974 did not have individual therapy sessions with the psychiatrist after the initial intake interview and prior to the time for discharge consideration. Thus, much of the responsibility for therapy is given to mental health technicians who are not fully trained to handle that responsibility.

Unit staff meetings are intended to help the mental health technicians with their therapy, and could serve as a training and supervisory mechanism for mental health technicians. However, from what we could learn of them from the staff and from observing two of those staff meetings, they appear inadequate in time and in depth to serve as effective training sessions.

About 15 mental health technicians in the past have undertaken a "family support program" training course provided with federal funds. The training was for two-person teams to help families, and occupied eight hours a week over nine months. However, the technicians were assigned to work with inpatients, not families, after their training.

Inadequate training in relation to assigned responsibilities of mental health technicians is not unique to the Institute. Essentially the same situation prevails in

¹⁴ Provided by O. Wahrenbrock, Department of Human Resources, Carson City, Nevada, May 13, 1974.

the Henderson and Las Vegas Mental Health Centers and in the Rural Clinics mental health program, as discussed in Chap. 8.

The occupational therapy program at the Institute in 1974 was an arts and crafts program that included occasional field trips with 20 to 25 residents for a luncheon.¹⁵ Providing residents with an opportunity for arts and crafts activity is commendable, but the limited hours of operation (3 1/2 per week in 1974) and the very low resident utilization rates are not. For the three-month period on which we collected statistics (March-May 1974) the average number of patient-hours of program usage per month was 1316 and the average of staff hours per month was 870. Thus, the average Institute resident receives only about one hour per week of "occupational therapy" and there is significant underutilization of this program's staff in that the ratio of patient-hours to staff-hours is only about 3 to 2 and could be much higher for this type of program. Residents could drop in wherever the center is open but the director indicated that few do. Rand staff members dropped in at the occupational therapy center unannounced four separate times over a period of months, and never saw more than four residents participating; the center's staff explained to us that most of the patient-hours of usage were accumulated via group usage. For example, one staff member escorting 27 residents out to lunch for three hours counts as 81 hours of occupational therapy. Geriatric patients were brought to the OT center in groups of about 15, three days a week, for one hour (the average was 213 patient-hours per month over the three-month period). Retarded people were also served in groups of about 15 each for one-half to one hour per week since most of them were on locked wards and were unable to come to the center alone (an average of 100 patient-hours per month for Ward 1 residents, 30 for Ward 2, 38 for Ward 3, and 136 for Ward 4). Participation by neuropsychiatric patients was voluntary.

When asked why use of the center was not higher, the director responded that residents of four of the five MR wards could not come by themselves, people on unlocked wards were not urged to come by the wards' staff, and that patients "hate two of my staff members."

One resident also told us that patients who had "success experiences" with certain crafts and wanted to pursue those crafts further were told they would be charged for materials, so they were discouraged from going back; the director of the OT center later confirmed this. The staff at the OT center consisted of six OT technicians who had no professional training, plus one professional occupational therapist who directed the center.

Since 1975, the occupational therapy and recreational therapy sections of the NMHI have been combined, and are now open to all residents 5 days a week from 8 A.M. to 8 P.M. and on Saturday from 8 A.M. to 4 P.M. With a new person in charge of this combined "activities therapy" program, the NMHI Director indicates significant change has occurred since we interviewed there.

At the time of our interviews and observation in mid-1974, the NMHI program for people with mental health disorders was seriously deficient in the area of pre-discharge planning and follow-up treatment after release of a patient. Continuity of care after discharge from NMHI was the exception rather than the rule. On the surface, everything appeared fine at first. A discharge planning committee exists,

¹⁵ Information in this section based on interviews with OT Center staff on April 24, 1974 and July 3, 1974, NMHI, Sparks, Nevada.

as do procedures for predischARGE planning and for smooth transition of patients from an Institute therapist to a mental health center therapist. Unfortunately, at the time of our interviews in 1974, neither the committee nor the procedures were functioning well. We were told that follow-up was provided not only by the mental health centers and Rural Clinics programs, but also by the Institute itself, which sent personnel into the field in addition to providing follow-up care to some patients at the Institute on a day care or outpatient basis. Subsequent interviews with direct service personnel in the Institute and in the other programs mentioned, and with former patients back at the Institute for another round of inpatient treatment, revealed that adequate follow-up services after discharge did exist for some patients, but apparently in practice were not provided for the *majority* of released neuropsychiatric patients who needed them. Rand's psychiatric consultants viewed this as a major problem with the Institute's program.

After describing the situation as it existed in mid-1974, we will outline plans the Institute has already made and some actions they have taken to partially remedy this problem, of which the Institute's administration was well aware.¹⁶

In the areas of predischARGE planning and transition of a patient from an Institute therapist to another program's therapist to promote needed continuity of care, the mid-1974 reality was as follows, as best we could determine from our interviews. For Nevadans released to rural areas of the state outside of Clark and Washoe Counties, there was usually no meaningful transition or follow-up by the public mental health service system. In the past, the Rural Clinics mental health program staff used to meet with all Institute patients from rural areas prior to discharge. In 1974, the Rural Clinics staff reportedly almost never saw a patient at the Institute prior to discharge. The Rural Clinics personnel were not providing adequate follow-up for most rural residents discharged from the Institute, and the Rural Clinics program lacked a sufficient number of skilled personnel to provide effective follow-up mental health services for all rural Nevadans released from the Institute and also fulfill their other responsibilities (see Chap. 8 for a discussion of the Rural Clinics program's deficiencies). For Institute patients from Clark County, none of the mental health programs in the Las Vegas area sent staff to meet with Institute patients from the Las Vegas area prior to discharge. Once back in Clark County, although the transition from treatment by the Institute to treatment by the Las Vegas Mental Health Center was an abrupt one, that Center had the capacity to provide adequate follow-up services. For Institute patients from Washoe County (the Reno area), the transition of a discharged patient to the follow-up care of the Reno Mental Health Center should have been easier because the Center and the Institute are in the same urban area. According to Institute staff, the typical predischARGE transition of patients to the Reno Mental Health Center was accomplished in mid-1974 by taking 7 to 10 patients in a group for one hour with a Reno Mental Health Center staff member. In the professional opinion of Rand's psychiatric consultant who conducted the interviews concerning follow-up,¹⁷ 10 patients cannot be effectively transferred with continuity of therapy from one therapist to another in one hour in a group setting. In the words of one of the Institute's psychiatrists, discharge and follow-up was a deficient and hasty matter of "bang, no transition."

¹⁶ Interview with Dr. V. LoCicero, Medical Director, NMHI, Sparks, Nevada, August 6, 1975.

¹⁷ Dr. A. Milstein.

The follow-up for discharged Institute patients by the Reno Mental Health Center was primarily medication. Two of the three direct service psychiatrists at the Institute, when asked to tell us what problem areas existed at the Institute, charged that the Reno Mental Health Center typically left the Institute psychiatrists' evaluation in the file (i.e., did not usually obtain the full Institute records on patients to be followed up), and a follow-up visit to the Center usually consisted solely of the Center's staff asking questions related to current medication before prescribing future medication. Follow-up by the Reno Mental Health Center typically consisted of only drug therapy, according to two Institute psychiatrists. Therefore, even if the Institute did an excellent job of diagnosis and treatment, the after-care provided at the Reno Mental Health Center was typically only medication supervision. Reno Mental Health Center records indicated that 75 percent of the patients receive primarily chemotherapy.¹⁸ As an example, one formerly discharged patient now back at the Institute told a Rand consulting psychiatrist that he had been sent to the Reno Mental Health Center after discharge, but he assumed it was for medication only, since that was all the Center staff member talked about in their 20-minute meetings every few weeks. The patient said he did not think to ask the staff member if he could talk about his problems. Instead, he tried to burn down his house to get the insurance money. One Institute psychiatrist posed the question of whether the Institute (i.e., the state) could be held legally responsible if a discharged Institute patient commits murder, because the follow-up by the Reno Mental Health Center "is known to be terrible." One Institute psychiatrist said he preferred sending his ex-patients to a private Reno psychiatrist if the patient could afford it.

According to Reno Mental Health Center personnel, the 25 percent of the patients primarily receiving psychotherapy had the opportunity to attend a group session three times a week. Predischarged and discharged people were seen in the same group, and 60 percent of those who attended at least one session were said to attend sessions for less than a month (including perhaps once before discharge). While Institute inpatients were permitted to come to the groups, the social worker who ran the groups said that they usually forgot to come or the staff on the ward did not remind them.

In defense of the Reno Mental Health Center, we note that in 1974 the center's Transition Unit at the Institute had only had one psychiatrist, one social worker, and a half-time secretary assigned to do preadmission screening, predischARGE planning, and postdischarge follow-up of all Institute patients from Washoe County. In July 1974, the active caseload of the Transition Unit was 140. The unit also was supposed to provide psychiatric consultation to the child and adolescent day treatment programs of the Reno Mental Health Center, and theoretically to provide outreach to patients who do not show up for appointments at the Transition Unit following discharge from the Institute. NMHI made follow-up appointments with the Reno Mental Health Center for about 90 percent of the Washoe County patients discharged. Most of those with appointments came to the Transition Unit for follow-up services at least one or two times. If they were active outpatients of the Transition Unit they were telephoned and sent a letter if they missed an appointment. Twice a week the social worker made field trips to the community to contact patients. Despite the Transition Unit's heavy responsibilities, the work done by the two staff

¹⁸ Interviews at the Reno Mental Health Center, Transition Unit, Sparks, Nevada, July 2, 1974.

members probably could have been increased. We scanned several weeks of scheduled appointments for the two staff members of the unit and found that a typical day had the two of them seeing a combined average total of only about 8 patients per day over a period of 2 to 3 hours. They also typically screened about two people per day prior to admission to the Institute. About 1½ hours per day, three days a week, were expended on group sessions by the social worker. Of the 80 work-hours per week the two men had, 40 hours were unscheduled. The men explained that this time was kept free so that one of them was available at all times during the working day to do immediate admission screening if needed. That time was also used for drop-in patients. The psychiatrist also said he typically spent an additional 18 hours per week in private practice outside his full-time job with the state. We note that with a different policy—namely, not requiring that someone be available at the Transition Unit *immediately* for admission screening—the effective time for direct service to patients could have been nearly doubled without adding any new staff members. This inefficient use of professional staff would have been more tolerable if patients were already getting all the follow-up they needed.

The Institute staff's perception of inadequate follow-up services by the Reno Mental Health Center led them to do some of the follow-up work themselves in 1974, even though they were already overburdened.

In mid-1974, the Institute provided several kinds of follow-up services. One neuropsychiatric ward had set up its own day treatment program, and those day-only patients (about 15) who came about three days a week accounted for about half the ward's caseload. We note that this amounted to inefficient use of an expensive full residential treatment facility for part-time day care only; it excluded patients in need of 24-hours-a-day, seven-days-a-week residential treatment. This day care was said to use a ward designed for residential treatment because no other day-treatment program exists in Washoe County, and outpatient follow-up services offered by the Reno Mental Health Center were felt to be inadequate for these patients.

Another type of follow-up was performed by one ward psychiatrist who had a private practice in which he saw about 8 ex-patients of the Institute, and by another who allowed ex-residents to see him at the Institute for follow-up therapy. Outreach and follow-up of former patients was also provided by one of the Institute's psychiatric nurses, who worked full time on these tasks. She saw only patients discharged to Washoe County, and of those only the 10 percent with the greatest need for follow-up in the opinion of the staff.

In 1975, the Institute staff stopped using the Reno Mental Health Center for follow-up service for Washoe County residents, and began to provide it themselves. The Reno MHC Transition Unit was phased out in November 1975.

According to the medical director of the Institute,¹⁰ the new neuropsychiatric service concept to be implemented will provide continuity of care and follow-up services by assigning responsibility for each Institute patient to a team of staff members.

For a patient from the Reno area, that team would comprise Institute staff members who would treat the person in the Institute, do all follow-up in the Reno area, including outpatient and day treatment if needed, and serve as a contact and coordination point to make sure that the person gets all services needed from all

¹⁰ Interview with Dr. V. LoCicero, August 6, 1975.

other service agencies. Under this plan they must therefore be "knowledgeable about all services." We do not endorse the concept of requiring already overburdened Institute staff members to be fully knowledgeable about and to coordinate all other service agencies for the individual. There is a clear need for coordination, or a direction service as we call it, but it can be provided better by the Regional Direction Centers we recommend in Chap. 4. For Institute patients from the Las Vegas area or rural counties, according to the Institute's medical director, the primary responsible staff member will be a therapist in the Las Vegas Mental Health Center or in the Rural Clinics Program. The Institute would then be seen as a secondary server providing temporary acute residential treatment services to an individual who is under the primary care and concern of the prime contact point in the hometown mental health program. The idea is for the Institute not to function as a chronic care institution, but to provide acute residential treatment followed by day treatment or outpatient treatment if needed. The actual residential population at the Institute would be reduced below what it is now, to free staff members from evening and night shifts and enable them to provide better service to the greater number of people who would be there during the day only. It is too early to tell how this will work out, but improved follow-up was clearly a major need throughout the state in 1974. Both improved day treatment capacity and outpatient services were clearly needed for ex-patients of the Institute. We also note that having a Rural Clinics program team responsible for follow-up is a good idea in theory, but that the program needs major staff improvements (see Chap. 8) before it will be a good idea in practice.

Since 1974, a "Community Liaison Program" has been in effect at the Institute. It currently has two staff members. The Institute's Director, T. Piepmeyer, indicates that "discharge planning has been upgraded and aftercare [outpatient] visits in January 1976 totaled 505." He also indicates "a fourth psychiatrist has been added to the Institute staff to coordinate the day care and partial hospitalization aspects of the Institute." In January 1976, NMHI provided 172 day care patient-days of service.

Problems of payment for drugs after the patient is discharged from the Institute (often running as high as \$40 to \$60 per month) were resolved by having the Institute provide free drugs to indigent discharged patients and sell them at cost to others.

A patient can apply for the Supplementary Security Income financial assistance program for disabled people only after discharge, and approval usually takes at least two months. In the interim, the county welfare departments reportedly will not provide financial assistance. Applications for Medicaid are not accepted until the person is officially accepted on a financial assistance program (see Chap. 14 for a discussion of those programs, and Chap. 12 for a description of Nevada's Medicaid program).

One other problem with follow-up services concerns those patients who were receiving chronic residential care at the Institute but were released to their families or to other residential facilities that usually have no mental health services. Other than the prescription of drugs and a visit from an Institute nurse to those other residential facilities every few months, we were told there is no follow-up by the Institute in 1974.²⁰ The Mental Health Centers and the Rural Clinics mental health

²⁰ This problem is not unique to Nevada. Julian Wolpert and Eileen R. Wolpert have prepared a stunning critique of the California system which contains many lessons of relevance and consequence

program could provide additional mental health services and supervision for those chronic patients, but they seldom do so.²¹

Dr. LoCicero, medical director of NMHI, said he is "not too happy" with the placement of people with chronic mental health problems from the Institute into group living facilities (e.g., skilled nursing facilities, intermediate care facilities, adult group care, and family care facilities described in Chaps. 12 and 13). He agrees they are "better than nothing," however, although "there could be much richer programming." He indicated that the residents receive drug therapy in those facilities, nursing care sometimes, but rarely any psychiatric or psychological services.²² The Nevada Welfare Division's Chief of Adult Services expressed his view that Nevada residents in adult group care and family care facilities (for which he has some responsibility) are provided a place to live, drugs if needed, and "nothing else" in the way of special services for any mental handicap if they have one (see Chap. 13 for a further discussion of those and other types of longer-term care types of facilities).²³

In a February 27, 1976 letter to Rand, Institute Director T. Piepmeyer points out that the "Community Liaison Nurse" made 148 contacts with discharged clients in January 1976 and that a "Geriatrics Community Action Team" from NMHI made 34 contacts that same month with discharged geriatric clients in skilled nursing facilities in the Reno area. Thus, he states, "the Institute, since 1974, has been able to visit most of our residents in skilled nursing facilities on a much more frequent basis than every few months, and to expand greatly the follow-up by the Community Liaison Nurse for discharged clients."

A major problem confronts the chronically mentally ill person who cannot function adequately in the community. There is a gap in the service system, well recognized by Dr. LoCicero and others at NMHI, between the full inpatient treatment NMHI is supposed to provide and the care provided with "normal" people in nursing homes or in the family. The administrator of the other Division of Mental Hygiene and Mental Retardation inpatient mental health treatment facility, Dr. L. Miller of the Las Vegas Mental Health Center, also pointed out the need for some type of longer-term residential mental health service program for people who do not need an intensive inpatient treatment program but cannot live in the community and need an extended residential mental health program of an intermediate level.²⁴

Some type of intermediate mental health care program is needed that provides loosely structured but sheltered living and perhaps sheltered work for some. Some direct mental health services also would be provided at this intermediate care facility (more than drugs) and some residents would be free to move about in the community during the day but return to this long-term sheltered living facility in the evening. The facility might also serve as a halfway house for someone who does not need full NMHI inpatient care but cannot live independently in the community.

for Nevada. See "The Relocation of Released Mental Hospital Patients into Residential Communities," *Policy Sciences* (forthcoming). See also R. Reich, "Care of the Chronically Mentally Ill: A National Diaprase," *American Journal of Psychiatry*, Vol. 130, No. 8, 1973, pp. 911ff, for some comments on the national scale.

²¹ Interview with Dr. V. LoCicero, NMHI, Sparks, Nevada, August 6, 1975.

²² Ibid.

²³ Interview with James Faehling, Chief of Adult Services, Nevada Welfare Division, Carson City, Nevada, August 1974.

²⁴ Interview with Dr. L. Miller, Las Vegas Mental Health Center, Las Vegas, Nevada, May 6, 1974.

In 1974 a task force of various service agencies was formed, chaired by Dr. Young of NMHI. Its original concern was what to do with chronic alcoholics, but it has expanded its attention to include all mental cases in which chronic care of an intermediate nature is needed. The task force had representatives of NMHI, the police, Indian service programs, welfare, rehabilitation, employment security, OEO, etc. According to Dr. LoCicero, the task force can name 50 or 60 people who have been involved with at least three agencies in the past year, and who need this intermediate care today in northern Nevada, but have no place to go for it. The task force was formed because some of these people had been routed from agency to agency and no one was adequately serving them. For example, Dr. LoCicero reported that one person cost the Nevada public at least \$30,000 and perhaps \$40,000 in one year by cycling from agency to agency.

The intermediate facility described above would serve people with chronic mental problems, such as ex-alcoholic patients with brain damage, organic brain syndrome mental patients in need of chronic care, and chronic schizophrenics, some of whom have been released from the Institute in the past and have come back to "haunt" other service agencies and even the Institute (which refuses to readmit them, according to Dr. LoCicero). A new facility is not necessarily needed; a new program in existing private or public facilities may be entirely adequate. We note that extended care facilities are not now in excess supply, at least in some parts of Nevada. For example, the *Clark County Plan for Health*, covering an area containing about half the state's population, has stated that "the critical shortage of adequate and well coordinated facilities and services for long-term treatment and care has emerged as one of the major health problems."²⁵ However, we note that some of the residents in existing long-term care facilities without mental health services are the same ones who need long-term intermediate levels of mental health care; for them, the need is not for all-new bed-spaces, but for new mental health services.

The point is that a progression of levels of service is needed in the state's mental health service system, ranging from outpatient to intensive inpatient residential treatment. If a portion of the service system does not exist, such as a longer-term intermediate care program, that gap should be filled. Until it is, portions of the existing service system should compensate for the gap. For example, in the current trend toward deinstitutionalization, if one discharges people from NMHI into group facilities without mental health services when those people really need an intermediate level of mental health services, those people may be worse off in the long run than they would have been if they were kept at NMHI. In other words, releasing people into an environment in which they are ill equipped to function may be worse than not releasing them.

The NMHI is accredited by the national Joint Commission on Accreditation of Hospitals as a psychiatric facility, but not as a mental retardation facility. Despite granting the Institute accreditation as a psychiatric facility, the JCAH included the following stern warning in its report:

Particular attention is drawn to the major deficiencies outlined above in sections:

²⁵ Clark County Areawide Comprehensive Health Planning Advisory Council, *Clark County Plan for Health*, Las Vegas, Nevada, December 1974, p. D-10.

Environment
 Dietetic services
 Patient education services
 Psychological services
 Outpatient services
 Partial hospitalization services
 Pharmaceutical services

These and other deficiencies must be corrected in order that accreditation may be maintained.²⁶

The deficiency in outpatient services and partial hospitalization services pertains to lack of a written plan for the referral of services not provided by the Institute. Since they were looking only at the Institute, the reviewers did not mention that in most geographic areas outside the Institute, outpatient services and partial hospitalization services (e.g., adult day treatment) are deficient (particularly in rural counties and Washoe County). Hence, even if the NMHI creates a written referral plan, there in effect may be nowhere to refer patients. Services by other programs as alternatives to residential treatment at the Institute or as follow-up to residential treatment at the Institute are beyond the scope of the JCAH survey of the Institute, but are a major area of deficiency we note in Nevada's mental health service system.

Another major deficiency noted in the JCAH survey pertains to psychological services: "There should be available a sufficient number of appropriately qualified staff and necessary supporting personnel to provide psychological services."

A major point is that even though a facility is accredited, the facility can still have "major deficiencies" in its programs. Some of those deficiencies are readily identified in the brief survey by JCAH; others are identifiable only after extensive probing (e.g., the low quality of the "psychotherapy" provided by the poorly trained mental health technicians on the neuropsychiatric wards, or the seriously deficient follow-up of discharged patients). In other words, there can be a chasm between policy and reality, theory and practice.

NEVADA MENTAL HEALTH INSTITUTE: GERIATRICS PROGRAM

In 1974 the NMHI had two wards housing about 80 geriatric patients.²⁷ Since the time of our interviews, the majority have been transferred out of the Institute, and the remaining 33 temporarily integrated with the Institute's neuropsychiatric wards pending transfer to facilities outside the Institute. In August 1975, we were told that only 33 of the 80 remained at the Institute, and nearly all of them were to be transferred to a new long-term skilled nursing facility in Las Vegas that has large fenced grounds that give patients some freedom of movement but prevent them from accidentally wandering off.²⁸ The facility staff will administer drugs and

²⁶ The report was attached to a letter from J. H. St. Louis, Psychiatric Hospitals Division, JCAH, Chicago, Illinois, to T. Piepmeyer, NMHI, Sparks, Nevada, April 18, 1975. It is given in its entirety in App. B.

²⁷ Information in this section is based on interviews with staff and residents of the Geriatrics wards, NMHI, Sparks, Nevada, July 1974.

²⁸ Interview with Dr. V. LoCicero, NMHI, Sparks, Nevada, August 6, 1975.

provide nursing and sheltered residential living service, but will not provide mental health services. Within the constraints of available work time, an Institute psychiatric nurse, and possibly other neuropsychiatric staff members, will provide some follow-up services after these residents are released from the Institute. However, since the Institute staff already has a very heavy inpatient workload, follow-up will probably be quite limited. Procedures call for the psychiatric nurse periodically to visit each long-term care facility that houses Institute residents, to check on the quality of care, the level of drugs needed by the patient, and so forth. Such follow-up is severely limited by the size of the staff assigned to it. The transfer of geriatric patients from the Institute has freed a number of staff members, who are now being used to improve services to the remaining neuropsychiatric patients.

In February 1976, the Institute Director informed us that references to the new long-term skilled nursing facility are premature since the contemplated facility is still trying to obtain financing for its construction. He indicates that follow-up for geriatric residents released has improved. The NMHI community action team made 34 contacts with discharged clients in January 1976, and 3 psychiatric teams are assigned to each of 3 skilled nursing facilities in Reno to provide consultative services on request.

A summary description of the former geriatric wards, their residents, and services for them, is provided here to point out how deficient services were for geriatric residents at the Institute as little as a year ago, because 33 of those residents are still at NMHI, and to caution against efforts to reinstate a geriatric program at NMHI like the one that is being terminated.

On the unlocked geriatric ward, the approximately 40 residents were all elderly. Few personal possessions were in evidence when we visited the ward. A nonpsychiatric physician was assigned to the two wards, but no psychiatrist or psychologist regularly provided direct services to patients. The one full-time NMHI psychologist, however, did help set up a toilet training program for incontinent geriatric residents, ran some problem-solving groups for residents, and provided consultation for the geriatric staff on setting up and running daily activity programs. The mental health technicians indicated that some physical therapy was provided on the unlocked geriatric ward, there were occasional bus rides and picnics, occupational (arts and crafts) therapy and recreational therapy were offered, and the physician provided annual physicals plus intake and discharge reviews of each patient with the staff. Residents engaged in one of various activities about once a day; a half-dozen people might go bowling or play cards, 15 or 20 people might go to a local church or social activity center, or a recreational therapist might come and sing with them. Rand's psychiatric consultant interviewed residents of the ward and concluded that most appeared to be merely passing the time; he believed there should have been many more activities.²² The staff members did not appear to actively encourage residents to leave the ward or participate in activities. Both Rand's psychiatric consultant and the Institute physician assigned to the ward believed that a majority of the residents needed an intermediate level of residential care, but did not need to be in the Mental Health Institute.

The locked geriatric ward housed some nongeriatric patients who were brought in from unlocked neuropsychiatric wards reportedly because of intractable behav-

²² Observations by Dr. A. Milstein, July 1974.

ior. Personal possessions were strongly discouraged on this ward; those that were allowed were kept in the nursing station. No personal possessions were allowed in residents' rooms. As on the unlocked geriatric ward, residents of this ward were not directly served by either a psychiatrist or a psychologist, even though many of the residents had major psychological problems. About 60 to 70 percent of the residents reportedly had a definite therapy program outlined for them. We asked specifically about the therapy programs for two of the nongeriatric residents on the ward. After considerable probing (by one of Rand's consultant psychiatrists) of mental health technicians responsible for implementing the "therapy programs," we learned that one of those patients had no specific therapy program in practice. The program for the other, a young female resident, consisted of trying to keep her looking attractive, plus psychotherapy—which, after considerable probing, was said to consist primarily of trying to teach her to say "cigarette" when she wanted one. Probably because of the small size of the staff assigned to the ward and the relatively low level of the staff's expertise and training, service to residents appeared to be primarily kindness and personal care. We stress that we are not criticizing the hardworking and dedicated staff, most of whom were doing their best within the limits of their skills.

The lack of purposeful activity among residents of the geriatric wards was documented in detail in an article published in 1974 by the Institute's psychologist. Quoting from the abstract to that article:

Of 43 residents in a hospital geriatric ward for regressed and disabled persons, only 3 were found to engage in some purposeful daily activity; the rest were relatively inactive. Under a regimen of programmed activities (e.g., bingo games) for one hour each afternoon, the daily average number of residents engaged in purposeful behavior rose to 13, but dropped to 3 again when the daily activities were discontinued.³⁰

When we asked why the program was discontinued, we were told that the wards did not have sufficient staff to continue it.

For the locked ward, it was the opinion of both Rand's psychiatric consultant who interviewed on the ward, and the Institute physician assigned to the ward, that the majority of the residents had stabilized conditions and needed a long-term intermediate level of residential care; it was believed that they could be adequately served in a fenced group-care facility and did not have to be in the Mental Health Institute. The Institute physician in charge of the geriatric wards indicated to us that up to 70 percent of the residents of both these wards could be served outside the Institute in group care facilities if funds were available and the facilities were fenced.³¹ We note that new fences and group care facilities providing intermediate levels of care can be significantly cheaper than the nearly \$12,000 per year per geriatric resident it cost the Institute until recently.³²

LAS VEGAS MENTAL HEALTH CENTER: RESIDENTIAL TREATMENT

The Las Vegas Mental Health Center provides a wide spectrum of services to

³⁰ H. Robert Quilitch, Ph.D., "Purposeful Activity Increases on Geriatric Ward Through Programmed Recreation," *Journal of the American Geriatrics Society*, Vol. 22, No. 5, May 1974.

³¹ Interview, NMHI, Sparks, Nevada, April 22, 1974.

³² Expenditure data for the Institute provided by Dr. V. LoCicero, April 22, 1974.

residents in a portion of Clark County: outpatient and inpatient services, partial hospitalization, emergency services, and consultation and education as required by the federal Community Mental Health Centers Act of 1963, which partially funds this center.³³ Another large portion of Las Vegas and Clark County is served by the Henderson Mental Health Center, which has no inpatient services. Chapter 8 of this report, on nonresidential mental health services, describes most of the services provided at the Las Vegas Mental Health Center; the present chapter considers only the center's inpatient mental health services, which are provided in a 16-bed adolescent unit and a 24-bed adult unit. As can be seen in Table 10.2, both units are operating well below full capacity; they were only about two-thirds full in the first quarter of FY 1975. The monthly turnover of inpatients (admissions/average census) was about 37 percent in the adolescent unit and 260 percent in the adult unit. Total FY 1974 inpatient admissions were about 50 adolescents and about 600 adults.

Table 10.2
RESIDENTIAL TREATMENT AT THE LAS VEGAS
MENTAL HEALTH CENTER

Program	FY 1974	FY 1975 (First Quarter Only)
Adolescent inpatient (16 beds)		
Average monthly admissions	4.08	3.7
Average daily census	9.73	10.1
Adult inpatient (24 beds)		
Average monthly admissions	49.67	43.0
Average daily census	19.15	16.4

SOURCE: Gov. M. O'Callaghan, State of Nevada, *The Executive Budget, Fiscal Years 1975-76 and 1976-77*, January 20, 1975.

Theoretically, the center is supposed to offer short-term care, while "long term patients from Clark County are transferred to the Nevada Mental Health Institute for extended care."³⁴ The number of patients transferred from the center to the Institute ranged from 0 to about 15 per month and averaged 9.3 in 1973. The center does provide short-term residential care, but the neuropsychiatric section of the Institute in practice accepts no children and almost no adolescents, and has a median stay for adult neuropsychiatric inpatients of only about two weeks—which is hardly "long term." The fact is that no state-operated mental health program in Nevada is providing any significant amount of "long-term" or "extended care." Only one or two neuropsychiatric patients at the Institute have been there over one year, and the medical director there indicated that the Institute is now functioning primarily as an acute care facility providing "temporary" services.³⁵

³³ Information in this section was obtained through interviews with Dr. L. Miller, T. Burke, and various staff members and inpatients of the Las Vegas Mental Health Center in March, July, and August 1974, and from a letter from L. Miller to J. S. Kakalik, The Rand Corporation, Santa Monica, California, February 27, 1976.

³⁴ *The Executive Budget*, p. 320.

³⁵ Interview with Dr. V. LoCicero, NMHI, Sparks, Nevada, August 6, 1975.

In 1974 the Las Vegas Mental Health Center had 52 staff positions for inpatient services (26½ for adolescents and 25½ for inpatient adults). However, 6 of those positions were not filled. In particular, the adult inpatient unit lacked its full-time psychiatrist, a half-time senior psychologist, and the social worker. The adolescent inpatient unit lacked both its full-time psychiatrist and its psychiatric social worker. At the time of our various summer 1974 interviews, the primary service personnel in the adolescent unit were mental health technicians supervised by a psychiatric nurse. We were told that outside of regular day-shift hours, inpatient admissions were made by mental health technicians, who typically had the same lack of training as their counterparts at NMHC. The Administrator of the Las Vegas Mental Health Center, in a February 27, 1976 letter to Rand, indicates that the "vast majority" of these senior professional positions are now filled, so several of the problems and situations that were observed in 1974 should no longer exist.

The center's actual FY 1974 expenditures were just over \$1.1 million, of which salaries accounted for about \$880,000. If one assumes that operating expenditures are split among units of the center in approximately the same proportions as staff, then the inpatient units (with about 50 percent of the filled staff positions at the center in mid-1974) incurred expenditures of approximately \$550,000; this amounts to about \$19,000 per inpatient-year.

LVMHC Adolescent Unit. During our interviews at the LVMHC unit,³⁰ the staff present on the unit consisted of three to five mental health technicians. Key senior staff positions were unfilled, as we indicated earlier, and hence the inadequately trained mental health technicians carried heavy treatment responsibilities without the guidance and supervision of the missing professionals. The problems we note below arise largely, but not entirely, from the unfilled senior staff positions.

Upon arrival, we and our psychiatrist-consultant observed a technician using what appeared to be excessive force on a patient who was walking on the grounds toward the parking lot. On the unit, the technician staff members were working on records, talking with one another, and engaging in what appeared to be unstructured discussions with the adolescent patients. There was little structure to the technicians' activities during our periods of observation; the staff members kept to themselves much of the time and the adolescents did pretty much what they wanted to without much direct contact with the staff. An impromptu informal staff meeting of available technicians was called in mid-afternoon; three of the adolescents were discussed, but not mainly in terms of their therapy. From what we could gather, the activities we observed were not atypical.

The general details of one particular case illustrate some apparent weaknesses in the unit's operation. A young adolescent girl had had prior admissions to the unit. The mental health technician directly responsible for the girl, her "advocate," was hazy and vague about key substantive points in her case. The technician could not adequately characterize her problem, could not indicate what, if any, treatment modality was being used for her, and did not even attempt to discuss what plan was being developed for the post-inpatient phase of her treatment. None of the other staff members on the unit had any knowledge of post-discharge service plans for this

³⁰ The unit was visited twice at unannounced times by both a Rand staff member and a Rand psychiatrist-consultant. A number of daytime hours were spent observing the unit and interviewing every staff member on duty. One of Rand's psychiatrist-consultants also talked with two randomly selected patients.

patient either. Finally, none of the staff members present on the unit, including her "advocate," were aware of the traumatic sexual molestation event that had immediately preceded the onset of her hallucinations, which twice had led to her admission to the unit as an inpatient. Rand's psychiatrist-consultant learned of this event in a brief interview with the patient. (One of the unit's missing professionals probably would have made the same discovery.)

The patients on the unit like the mental health technicians, however, and in general the technicians themselves appeared to be hard-working people who are interested in helping the patients. The problem is that the technicians are inadequately trained for their highly important and responsible jobs, and they were inadequately supervised and directed in mid-1974. The subsequent filling of the open professional positions should have resolved many of the problems of supervision and of discharge planning, but the problem of lack of training of the technician staff will still require special attention. It is a problem throughout the state's mental health service programs wherever "mental health technicians" are employed. (See Chap. 8 and other sections of this chapter for particulars.)

LVMHC Adult Inpatient Unit. As in the adolescent unit, our observations and interviews at the adult inpatient unit of the Las Vegas Mental Health Center indicated a rather unstructured unit, staffed primarily by relatively untrained and unsupervised mental health technicians in mid-1974. Key professional staff positions were unfilled, and the following scenes probably resulted partially from that fact.

The scene was frankly rather chaotic on the unit. A young girl about 12 years old (a resident of the *adult* unit) was very actively agitating patients, attempting to agitate technicians, throwing her dinner around, and being generally uncontrolled and disruptive while the staff did nothing about her behavior.

Another patient, an uncommunicative older woman, was unrestrained in her agitation of other patients for a long time period. First, she poured glasses of water on herself and other patients. Then she nearly got into a fist-fight with a highly distressed young man who was just being admitted (a process that took almost an hour in the confusion). At one point a staff member came in from the day-care unit and offered the young man a cigarette if he would calm down. He did so until the woman grabbed his extra clothes and started throwing them around the area. He became further agitated and had his cigarette taken away. Finally, a technician emerged from the office and tied the woman in a wheelchair, where she was ignored while screaming at the top of her lungs. In the opinion of Rand's psychiatrist-consultant, based on interviews with the staff, such drama was probably due neither to a lack of mental health technicians nor to his presence and that of a Rand staff member on the unit, but instead was probably due to the technician staff's not knowing what to do—again, that is, due to their inadequate training and supervision.

One patient interviewed was in the process of being discharged that afternoon. His situation further illustrated the problem of lack of preplanning and follow-up. Neither he nor the technician staff knew where he was going after discharge or where he would sleep that night; he had no family or friends to receive him; and a member of the technician staff said they had begun to plan his discharge only about two hours earlier. The man's primary mental health technician (whose name the man did not know) said the patient was ready for discharge, but Rand's psychiatrist-consultant, who interviewed the patient, did not share that opinion.

To check on the level of knowledge the mental health technicians on this unit had concerning the patients they were primarily responsible for, our psychiatrist-consultant selected a few patient records at random, found the technicians responsible for the patients, and quizzed them about key information on the patients. The technicians' responses were typically weak, or they did not know the information that, in our consultant's opinion, was fundamental and essential to providing good treatment. As an illustration, the technician responsible for the man described above who was about to be discharged could not answer our question, "Where is he going to sleep tonight?" The technician also did not know the circumstances of the man's admission, his family situation, or his economic situation, nor had the technician sought out higher-level professional assistance in the care of this nondisruptive patient. The discharge rates of inpatients from this facility within a short time after admission are respectably high, but we had serious doubts about the preparedness of the patients for discharge.

Another possible problem concerns the participation of physicians in these patients' cases, which one of our psychiatrist-consultants described as "shadowy." For example, two separate cases were found in which the mental health technician staff told our psychiatrist-consultants that a patient's condition had been described over the telephone to a Mental Health Center physician, who then prescribed drugs. According to the mental health technician staff, telephone orders allegedly included the administration of lithium without the prudent accompanying lab test recommended for its safe use. Such lab tests would be particularly important when ordering lithium for a patient without having a physician clinically evaluate the patient firsthand. This and similar practices, where physicians and their employers assume responsibility for the administration of potentially toxic medications without thorough first-hand appraisal of the patient at the time, involve potential vulnerability on legal grounds. Recall that the psychiatrist positions were unfilled at both the LVMHC inpatient units when we interviewed; the subsequent filling of those positions probably has resolved the alleged drug-prescription problems.

The foregoing anecdotes illustrate some of the problems whose existence is confirmed by numerous interviews with high- and low-level staff members and with patients, and by a review of patient records. The following were the major deficiencies apparent in the Las Vegas Mental Health Center's inpatient operations in mid-1974: unfilled key professional staff positions; inadequate training of mental health technicians; insufficient supervision of mental health technicians by higher-level professional staff; and inadequate planning for the period following discharge as an inpatient. However, in defense and explanation of the situation at the Las Vegas Mental Health Center, we note that it is a fine, relatively new facility that was not yet fully professionally staffed at the time of our series of visits in 1974. When it is fully staffed, and when supervisory follow-up and other procedures are ironed out and fully implemented as the center's programs mature, all of the problems noted except one can be readily solved. In the area of follow-up, for example, the center now has developed an "Advocacy/Aftercare Program" whose major function is to provide follow-up services to former inpatients of the Las Vegas MHC and the NMHI, and generally to monitor and implement continuity of care. The problem we feel most difficult to resolve is that of the inadequate training of the mental health technicians—the staff members who have the most contact with the inpatients.

CHILDREN'S BEHAVIORAL SERVICES: RESIDENTIAL TREATMENT

The 1975 session of the Nevada Legislature approved \$1,450,800 for the construction of a Northern Nevada Emotionally Disturbed Children's Facility in Reno, to be part of the Children's Behavioral Services (CBS) program. The building complex will be identical to that already under construction for emotionally disturbed children up to age 13 in Las Vegas. It includes residential units for short-term intensive inpatient treatment of a maximum of 16 highly mentally disturbed youths, plus a classroom and outpatient service building.³⁷ The levels of services to be offered in Reno range from 24-hour residential inpatient service, through transitional residential placement with specially trained professional parents outside the facility, conventional foster home care, services during the full day, and on through outpatient services. Residential services existing in early 1976 in the Las Vegas CBS program are similar, and are detailed in Chap. 8. Residential intensive services, day care, and outpatient services at each facility are expected to reach about 40, 74, and 500 emotionally disturbed children per year, respectively.³⁸

Regarding the need for CBS services, we conservatively estimated in Chap. 3 that at least 2 percent of Nevada's children have emotional disturbances of sufficient severity to require substantial special services in any given year. Since there are about 195,000 children and youth aged 0 to 18 years in Nevada, this means at least about 4000 need substantial services for emotional disturbance. About 2500 are aged 0 to 12 years. In February 1974, the Nevada Division of Mental Hygiene and Mental Retardation conducted a survey of agencies in Washoe County and the surrounding northern Nevada area, asking how many children aged 0 to 12 years they knew of who were emotionally disturbed. The agencies reported 57 very severely, 147 severely, and 1461 moderately disturbed children.³⁹ Those results exceed the 2-percent figure we are using in this report, but our figure is a conservative minimum estimate.

Both parents and children will be involved in CBS services. CBS will offer family counseling, group therapy for parents and children, classes for parents in effective management techniques, individual therapy for children, and an evaluation service. Evaluation will include a medical and a behavioral assessment of the child, and an evaluation of the strengths in his or her social environment. See Chap. 8 for a description of the February 1976 CBS program in Las Vegas.

Since the CBS facility in Washoe County is not yet complete, the 1975 session

³⁷ *The Executive Budget*, and an attachment to a letter from J. Burnett, CBS, Las Vegas, Nevada, to J. S. Kakalik, The Rand Corporation, Santa Monica, California, February 27, 1976.

³⁸ Nevada Division of Mental Hygiene and Mental Retardation, *Children's Behavioral Services—Washoe County*, Department of Human Resources, Reno, Nevada, February 1975.

³⁹ Division of Mental Hygiene and Mental Retardation, *A Proposed Treatment Program for Emotionally Disturbed Children in Washoe County*, Nevada Department of Human Resources, Reno, Nevada, August 1974. The definitions used in that report are:

- (1) Very severely emotionally disturbed (typically called psychotic, autistic, etc.). Such behavior might include: bizarre thinking, hallucinations, nonspeaking and noncommunication, severe self-mutilation, and the like.
- (2) Severely emotionally disturbed. Such children may have two or more problems of a serious nature, such as extreme and unreasoning fears, unusual sexual preoccupations or perversions, cruelty to animals or children, severe shyness and social withdrawal, habitual fire-setting, etc.
- (3) Moderately disturbed. Such behavior may be marked by habitual lying, truancy, theft, emotional dependency, lack of friendships, continual feelings of worthlessness and unhappiness, etc.

of the legislature approved only about \$47,000 in salaries for four staff positions to start up the new program. Since the CBS facility in Clark County was near completion, the 1975 legislature approved \$161,000 a year in salaries for new staff positions there, over and above the 17 FY 1974 staff positions: a pediatrician or psychiatrist, two child development specialists, three sets of "professional parents," a relief parent, and a custodial worker. Seven additional positions were authorized, conditional on receipt of sufficient Federal Social Services funds which have now been obtained.⁴⁰ We have two comments about the staffing. First, a physician with specialty training in psychiatry should be hired since some of the children undoubtedly will need psychiatric services (see Chap. 8 for a discussion of the desirability of offering a range of treatment modalities). CBS might be fortunate enough to hire a physician with speciality training in both psychiatry and pediatrics; if not, then the program would also need to provide for pediatric services on at least a part-time consultant basis. Second, the staff conditionally authorized can be effectively used; services would have suffered markedly if the funds had not been there to hire them.

MEDICAL FACILITIES WITH PSYCHIATRIC UNITS

While Nevada's medical facilities are discussed in general in Chap. 12, we discuss the four psychiatric units here. In 1973, for all Nevada general hospitals with psychiatric services, there was a total of 1776 psychiatric patient-discharges.⁴¹

Cedarbrook Hospital

The 21-bed Cedarbrook Hospital in Las Vegas primarily provides inpatient chronic care for psychiatric patients.⁴² The patient census of October 31, 1974 included one alcoholic and ten adult psychiatric patients. Until it changed ownership recently, it was primarily an alcohol detoxification and treatment hospital. The primary professional staff consists of three psychiatrists; a child psychiatrist also is affiliated with the hospital. It is the only Las Vegas hospital that nearby Nellis Air Force Base uses for psychiatric patients. The fees (October 1974) were \$82.50 per day plus the cost of group therapy if appropriate (\$20), doctor's fees, medication, and any special procedures.

Rancho Vegas Nursing Center

Rancho Vegas Nursing Center planned to reopen a 39-bed wing of a building in October 1974 for the provision of long-term psychiatric care.⁴³

Southern Nevada Memorial Hospital

The neuropsychiatric unit of Southern Nevada Memorial Hospital in Las Vegas

⁴⁰ Information provided by H. Clemons, Management Analyst, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, June 20, 1975.

⁴¹ Unpublished data provided by the Office of Demography and Mental Health Statistics, Survey and Reports Branch, Division of Biometry, National Institute of Mental Health, Department of Health, Education, and Welfare, Rockville, Maryland, September 29, 1975.

⁴² Interview with T. Mikkelsen, Administrator, Cedarbrook Hospital, Las Vegas, Nevada, October 31, 1974.

⁴³ Interview with Mr. Feist, Director, Rancho Vegas Nursing Center, Inc., Las Vegas, Nevada, September 1974.

has 24 beds. About half the beds are used for private patients and half as a "disposition and holding area" for patients with court decisions pending on their mental health status.⁴⁴ Dr. W. B. Pike, the psychiatrist in charge of the unit in 1974, served the private patients and also provided psychiatric information on patients to the 8 to 10 judges responsible for commitment hearings on a rotating basis. Juveniles were seen on the unit only as private patients; rural residents were said to be rare. The unit had about 80 to 100 patient admissions per month. In mid-1974 the average patient-stay was 5 or 6 days, and the primary treatment modality was drug therapy.

Follow-up after discharge was not done in 1974 except for private patients or other patients who specifically requested it; the stated reason was that the nearby Las Vegas Mental Health Center would be providing the service. At the time of our interviews, however, there was a conspicuous lack of communication and cooperation between the hospital and the mental health center, and referrals to the center for follow-up services were only rarely made. The psychiatrist in charge of the neuropsychiatric unit at the Hospital disliked referring his patients to the mental health center because, in his opinion, "They don't have adequate psychiatric back-up." (Since our interviews in mid-1974, the mental health center has improved its psychiatric staff.)

Washoe Medical Center

The Washoe Medical Center, a general hospital in Reno, has a 30-bed psychiatric unit. It is the only private inpatient psychiatric unit in the Reno area, and all admissions are voluntary.⁴⁵ No outpatient psychiatric services are provided. A few private psychiatric patients go to St. Mary's Hospital in Reno, but there are reportedly no special psychiatric services there.

In April 1974, the nonunionized hospital charged psychiatric patients \$65 per day plus private physicians' fees, drugs, and laboratory fees. There were no psychiatrists or psychiatric social workers on the hospital staff. All psychotherapy was provided, usually daily, by each private psychiatrist to his or her own patients; none was provided by the hospital, although a psychiatric nurse supervised the unit. Five of the ten psychiatrists in the Reno area in April 1974 regularly used the Washoe Medical Center.

Each patient could participate in two hours of arts and crafts per day, one-half hour of exercise, and three or four hours of work (considered to be therapy to build work skills, work tolerance, and social interactions). An occupational therapist tried to make sure each discharged patient had a job, if working was appropriate, and a nurse followed up after patient discharge.

NEVADA STATE PRISON

In August 1974, when we gathered information⁴⁶ on mentally handicapped

⁴⁴ Interviews with Dr. W. B. Pike and Dr. O. Ravenholt, Southern Nevada Memorial Hospital, Las Vegas, Nevada, July 16-17, 1974, and August 8, 1974.

⁴⁵ Interview with Carroll Ogren, Washoe Medical Center, Reno, Nevada, April 23, 1974.

⁴⁶ Interviews with Warden Pogue, the Correctional Officer on the psychiatric unit, and the inmate-attendant on the unit, Nevada State Prison, Carson City, Nevada, August 1974. Later information in this

people in prison in Nevada and the services or lack of services for them, there were five different groups of people of concern to this study: an unknown number of mentally retarded prisoners; about 10 mentally ill convicted prisoners not living in the "psychiatric unit" of the Nevada State Prison; about 5 mentally ill prisoners convicted of crimes and living in the psychiatric unit; 8 unconvicted prisoners in the psychiatric unit and elsewhere in the prison with criminal charges pending against them but whom the court has deemed temporarily mentally unfit for trial; and one or two unconvicted mentally ill persons against whom no criminal charges are pending but who have been sent from the NMHI to the Nevada State Prison because the Institute by policy choice did not have a secure locked unit for them. (See also Chap. 13 for a discussion of the juvenile justice system, which handles some youths with mental health service needs.)

We found conditions for mentally handicapped people at the Nevada State Prison in August 1974 to be extremely bad. We shall proceed to describe conditions as we found them at the prison, but inform the reader that the warden and new consultant mental health professionals have improved the program since we interviewed, that a court order was issued in early 1975 evacuating people from the psychiatric unit who had not been convicted of crimes, and that a new small Mentally Disordered Offender Facility was approved by the legislature in 1973 and is to open in 1976. However, the majority of the mentally handicapped prisoners were not in the psychiatric unit, and the number of prisoners with mental health problems exceeds the capacity of the small Mentally Disordered Offender Facility under construction. We also think it important to show how bad the programs have been at the Nevada State Prison recently both by way of illustrating how services are improving and as a caution that there is still a long way to go—and only a short way back if matters go awry.

Nevada State Prison: The Psychiatric Unit

The psychiatric unit of the Nevada State Prison was a special area of the maximum security prison that was supposed to provide residential treatment for inmates needing mental health services. As described by the Nevada Commission on Crime, Delinquency, and Corrections,

... this unit is concerned with the treatment of those inmates requiring intensive care. Through the help of inmate attendants, these patients are under 24 hour care and observation. A recreational day room on the unit provides opportunities for intensive psychotherapy on both a group and individual level.⁴⁷

Several prisoners on the unit had not been convicted of crimes in mid-1974. Some had not even been charged with crimes but had been civilly committed, their only "crime" being a district court finding that each was "mentally ill and, because of that illness . . . likely to injure himself or others if allowed to remain at liberty. . . ."⁴⁸

section was provided in a letter from Warden Pogue to J. S. Kakalik, The Rand Corporation, Santa Monica, California, March 8, 1976 and a letter from Dr. D. Molde, psychiatrist, Reno, Nevada, to The Rand Corporation, March 11, 1976.

⁴⁷ Commission on Crime, Delinquency, and Corrections, *State of Nevada Comprehensive Criminal Justice Plan*, Vol. 1, 1974, p. A-1-243.

⁴⁸ *Nevada Revised Statutes*, 433.695. This definition applied at the time of our interviews in 1974; it has been revised somewhat by the 1975 legislative session (see Chap. 3).

They received very little treatment in mid-1974 other than drugs. The inmate-attendants did not "help" provide direct 24-hour care—they provided nearly all of it. Almost no psychotherapy was provided since there was no regular staff on the ward qualified to do so, and professionally qualified staff spent very little time on the unit.

The psychiatric unit was located on the prison's former death row, in an old Territorial prison building that was in use before Nevada became a state. The unit has room for 12 beds; there are eight cells in the main area, two beds in an open-office area (which are used only in emergencies), and two beds in the "condemned area" facing the gas chamber.⁴⁹ The small area of each cell contains a single bed and a sink-toilet combination. We observed no personal possessions in most cells. Floors are concrete and some were damp; one cell had broken plumbing repaired with towels. The activity room contained a Ping-Pong table, some chairs, and a television set. The unit's office, where we were told the prison psychiatrist was supposed to provide direct services, also contains the gas chamber secluded by curtains. The private psychiatrist serving the unit part-time in March 1976 points out that the physical facility is "quite satisfactory, given the alternatives within the maximum security prison." He continues: "In fact, this unit is the most desirable place to live of any of the housing arrangements which are available at that prison."

One correctional officer functioned as manager of the psychiatric unit. He stated that all he did was guard the prisoners, that he had no responsibility for treatment. The unit had a staff of four inmates, one on duty at night and three during the day. No one working each day on the psychiatric unit had any formal training in the mental health area. We were told that the inmate-attendant in charge administered psychotropic drugs. One might well ask, as we did extensively of the warden, the correctional officer, and the inmate-attendant on the psychiatric unit, where the professional mental health personnel were and what services they provided. After all, like Nevada's legislators who approved the budget and staff, we knew that the administrator of the Division of Mental Hygiene and Mental Retardation is responsible for the supervision of the psychiatric care and treatment provided for the mentally ill prisoners at the Nevada State Prison,⁵⁰ and that the prison had staff positions for a psychiatrist, a psychologist, and a psychiatric social worker. In reality, these positions are under the warden's supervision and are intended to serve the maximum security prison, which holds about 425 men; the medium security prison, which holds about 375; and a women's prison, which holds about 35. In effect, however, even these staff positions exaggerate the psychological services available to the prison population. At the time of our interviews at the prison in August 1974, the psychiatric social worker worked his 20 hours a week at the medium security prison, running encounter groups for drug offenders. The prison psychiatrist and psychologist had recently terminated their employment with the prison, and the warden indicated that the budget for the psychologist position probably would be used to hire a male registered nurse. Before he quit, the psychiatrist split his 40

⁴⁹ This unit has been described by a psychiatrist, Dr. R. Komisaruk, as "a macabre example of what the inmate technician called behavioral modification. The two cells which were historically used as the night-before cells (on death row) are now used as a positive reinforcement Because there is more room in the cells, patients are rewarded for good behavior by being kept in those cells. It seemed like an unusually grisly situation." *The Nevada State Journal*, May 11, 1974.

⁵⁰ *Nevada Revised Statutes*, 433.320.

hours a week among the three prisons and had to spend a large fraction of his time on administrative and testing matters (e.g., classification of new prisoners, parole meetings, and parole reports). According to the correctional officer on the psychiatric unit in August 1974, the psychiatrist who had recently terminated employment provided little psychotherapy for prisoners on the unit. In a separate interview, the inmate-attendant corroborated this. The warden, however, indicated it was his understanding that the psychiatrist in mid-1974 was providing "daily attention to the people in the psychiatric unit as well as in the general populations at the other institutions."

Until a new psychiatrist could be hired, two private psychiatrists were filling in at the prison for ten to fourteen hours a week between them. Thus, a job that left little time for direct services at 40 hours a week was left to be performed in less than half that time. Prior to the departure of the psychologist from prison employment, he was used to train staff members throughout the prisons.

As of March 8, 1976, the warden still had not been able to recruit a full time psychiatrist; the March 1976 mental health services personnel include approximately 10 to 14 hours per week of psychiatric coverage, primarily to the Maximum Security Prison and to the Women's Prison, and approximately 20 hours per week of a certified psychologist's time to provide direct clinical services to the maximum and (primarily) medium security prison's population. Currently these two private mental health professionals see approximately 30 to 40 inmates per week. As of March 1976, some of these individuals are in extended treatment; some are seen for drug treatment or other brief contact; some are seen for parole board reports, for recommendations for jobs, housing, or other institutional activities; and some are seen on an emergency basis.

The private psychiatrist serving the psychiatric unit part time in March 1976 indicated that the chief inmate-attendant still distributes medication on the unit. The inmate-attendant does so under supervision of the correctional officer in charge and also under the supervision of the medical technicians and (in the past) also under the supervision of a registered nurse. The psychiatrist also stated that "because the Nevada State Prison, like many other institutions, depends upon inmate assistance for its full operation and because there is simply no sufficient budget to employ civilians in all the desirable capacities, we are forced to use inmates for this purpose." The warden desires to increase the quantity and quality of mental health services at the prison, and plans to increase the amount of psychological and psychiatric coverage, probably on July 1, 1976.

The typical day of psychiatric unit inmates consisted of breakfast, medication, exercise (if they wanted it), lunch, and more exercise. From 3:30 p.m. until 7:30 a.m. they were locked in their cells, since no correctional officer was assigned full-time to the unit on the evening and night workshifts, or on weekends.

Of the ten men housed in the psychiatric unit, over half were in the prison on civil commitments.

Criminal commitments have determinate maximum sentences. If considered mentally ill when it is time for release, the prisoner is taken to court and the judge is asked for a civil commitment. If the judge grants it the former prisoner is sent to the Nevada Mental Health Institute. Technically, he could be sent back to prison from the Institute, but the warden says that has never been done.

Civil commitments usually have indeterminate sentences. Theoretically, a per-

son charged but never convicted of a crime could remain incarcerated longer than if he were convicted. Also theoretically, a physician is supposed to review the mental condition of prisoners with civil commitments every six months.

As can be imagined, length of stay varied greatly. Some stayed in the psychiatric unit for three to six months, others as long as five to seven years. In August 1974, only two had been there less than a year. Three had been there more than five years, of whom one convicted criminal was a 13-year resident.

It came as no surprise to us when U.S. District Judge Bruce Thompson, ruling in February 1975 on a class action suit on behalf of inmates, ordered that prisoners who had not been convicted of crimes be evacuated from the prison psychiatric unit. As a result of the order, several inmates of the unit were sent out of state to other facilities (e.g., Atascadero State Hospital, and a private psychiatric facility in Walnut Creek, California). Two were transferred to the NMHI; of those two, one walked away from the Institute, which at the time had a policy of not having any locked neuropsychiatric unit, and one was sent to county jail after allegedly abusing a female mentally retarded resident of the Institute.⁵¹ Since that time, and while awaiting completion of the new Mentally Disordered Offender Facility, the Institute has created a secure neuropsychiatric unit with a capacity of 10 to 12 inpatients.⁵²

Nevada State Prison: Nonpsychiatric Units

The Nevada State Prison system does not know even approximately how many mentally retarded prisoners it has, and provides no special services for them, other than allowing them to participate in basic adult and remedial education classes. According to national 1963 prison population figures, approximately 10 percent of the inmates in the entire United States prison system were mentally retarded⁵³ (defined by the source of the data as having measured intelligence below IQ 70). Approximately 40 percent had a measured IQ below 85. This proportion is well above the 3 percent of the entire United States population with measured IQ below 70. Yet, there is no provision for removing the mentally retarded offender from the Nevada State Prison and providing him or her with special services elsewhere in the mental retardation service system.

Women in 1974 received no psychiatric services at the women's prison; those most in need were sent to California prisons for care and treatment (one was in California at the time of our interview).

For men, in addition to the psychiatric unit (with 10 prisoners), the prison has set aside one tier of the maximum security prison (with 42 prisoners) for men described to us as either psychotics or sociopaths. Nearly all were said to be on behavior-controlling drugs but received no other psychological services. It was reported that one man on this tier was there on a civil commitment.

In general, in mid-1974, apart from chemical restraints used primarily to control behavior, no psychological services were offered outside the psychiatric unit other

⁵¹ Interview with Dr. G. O'Bryan, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, June 1975, and letter from R. Hiller, Nevada Division of Mental Hygiene and Mental Retardation to J. Kakalik, The Rand Corporation, March 4, 1976.

⁵² Interview with Dr. V. LoCicero, Medical Director, NMHI, Sparks, Nevada, August 6, 1975.

⁵³ *A National Survey of the Diagnosis and Treatment of Mentally Retarded Offenders in Correctional Institutions*, Project CAMIO, Division of Mental Retardation, Social and Rehabilitation Service, United States Department of Health, Education, and Welfare, December 1973.

than group therapy to drug offenders. In response to a prisoner's public complaints about lack of psychiatric care, the warden testified that there was no group therapy or other psychiatric resources readily available to "normal" inmates of the maximum security facility—that such care went primarily to mental cases in custody and others who were committed as psychotic.⁵⁴

Six months later, the director of the NMHI said that a sex offender who had been declared insane "while housed in the medium security area of the state prison, would have access to psychiatric treatment and might some day be declared fit for release."⁵⁵ Such public statements, which wrongly imply the general availability of mental health services, can only worsen an already serious situation.

MENTALLY DISORDERED OFFENDER FACILITY

The new Mentally Disordered Offender Facility (to be called "Lake's Crossing Learning Community") will be a 32-bed residential mental health treatment facility. Now under construction at a cost of \$1.6 million, it is scheduled to open in 1976. It is to be operated by the Nevada Division of Mental Hygiene and Mental Retardation and is intended to serve four groups of people. All four are groups that formerly were supposed to have been receiving mental health services in the Nevada State Prison system: persons judged not guilty because of mental disorders; persons judged not competent to stand trial because of mental disorders; persons who develop mental disorders while convicts; and persons who commit certain sex offenses. Division of Mental Hygiene and Mental Retardation personnel, including the medical director of the NMHI, have also spoken of using the new facility for service to those people requiring mental health treatment in a secure facility who formerly would have been served by the NMHI when it had a secure ward in its neuropsychiatric unit.

The staff approved by the 1975 legislature for the Mentally Disordered Offender Facility includes a clinic administrator, a psychiatrist, two psychologists, a psychiatric nurse, a psychiatric social worker, an occupational therapist, a recreational therapist, a security officer, 23 mental health technicians, and four secretarial and housekeeping personnel.

The number of prisoners in the Nevada State Prison system at the time of our interviews who belong to the four groups cited exceeds the planned capacity of the Mentally Disordered Offender Facility. It is therefore obvious that either treatment at the new facility will be short term and the prisoners will be returned to the criminal justice system (i.e., the court or a prison facility), or some prisoners will not be served at the new facility. The program statement given in the January 1975 *Executive Budget* points to short-term treatment:

The concept of a therapeutic community will be emphasized with an effort made by the program staff to develop a normalized community within the Facility which will support productive, appropriate behavior. Hopefully, treatment will be of a relatively short-term nature, with the goal of returning the individual as quickly as is consistent with competent treatment to his natural environment or the criminal justice system.

⁵⁴ *Nevada State Journal*, January 20, 1974.

⁵⁵ *Las Vegas Review Journal*, June 6, 1974.

We note that the "therapeutic community" concept, widely used in short-term facilities, is difficult to implement in the short term since the concept is based on patients becoming meaningful participants in a "community" in which power and other values are shared. No matter how the Mentally Disordered Offender Facility functions, the Nevada State Prison will continue to house prisoners who have an unfulfilled need for mental health services because the Mentally Disordered Offender Facility could not make room for them, or because they need follow-up mental health services after intensive treatment at the new facility.

OUT-OF-STATE RESIDENTIAL SERVICES

In 1974 there was no residential mental health treatment program for children and youth, either public or private, in northern Nevada. The NMHI only accepts mental health patients in their high teens or older. The only public facility in the entire state with a residential mental health treatment program for youth was the Las Vegas Mental Health Center, and it accepted only youths over 12 years of age from the Las Vegas area. Children under 12 were not served anywhere in the state in a public residential mental health treatment program, and were served only on a very short-term basis with adults in psychiatric units of local and private hospitals.

Consequently, some children with the most severe mental health problems requiring residential treatment were sent to mental facilities out of state. Others were not served at all.⁵⁶ Still others ended up in places such as the two Nevada Training Centers for delinquent youth or in the two Nevada Children's Homes, which are not intended to offer mental health treatment programs (see Chap. 13 for details). The two CBS facilities, when completed, will partially rectify this problem.

The following case studies, provided to us (without identifying names) by Washoe County Juvenile Probation Department personnel and Child Welfare personnel of the Nevada Welfare Division, trace the bouncing of emotionally disturbed children through the various agencies of the social service delivery system until they are finally sent out of state:

One case involved an emotionally disturbed 16-year-old juvenile who had been in and out of various mental health and correctional institutions since he was 8 years old. When we saw him in the fall of 1974, he had run away from the NMHI twelve times in the past two months. Probation officers complained bitterly to us that he sometimes got out of NMHI so fast that on one occasion they passed him hitchhiking on the road just after they had dropped him off at the Institute. At the time of our interview, he was being held at Wittenberg Hall (a temporary juvenile holding rather than treatment facility). The Department of Juvenile Probation was preparing to take the Welfare Division to court in order to force them to provide services not otherwise available in the state for this emotionally disturbed boy.⁵⁷

⁵⁶ For example, when we interviewed in July 1974 at the day-care program for emotionally disturbed children and youth run by the Reno Mental Health Center (see Chap. 8), the program's administrator listed 24 youth whose emotional disturbances were too severe to be treated in a day-care program. They were unserved because there was no residential service program for them.

⁵⁷ Three years ago the Department of Juvenile Probation reportedly took the Welfare Division to court to make the state accept responsibility for a child who was not getting essential residential mental health services. According to the Juvenile Probation officials, Welfare has taken the position that no matter how emotionally disturbed or mentally retarded a child is, once he has been declared a delinquent, Welfare is not responsible. In each of the six cases thus far tried, the judge has ruled that the Welfare Division

One 18-year-old emotionally disturbed and mentally retarded Nevada youth had been placed in various institutions in Utah, Texas, and California over a period of years by the Welfare Division prior to his return to Nevada at age 18 for "normalization." On return, he threatened his new foster parents and was taken to the NMHI, which reportedly refused to accept him because it was after 5 p.m. He spent the night in jail.

One brain-damaged, severely emotionally disturbed 10-year-old was placed in an institution in Texas after NMHI reportedly refused to admit him because they had no appropriate service program for him.

Another 17-year-old severely emotionally disturbed youth had been shuffled from agency to agency. He had been in various foster homes, the Las Vegas Mental Health Center, the Nevada Youth Training Center for delinquents, the NMHI, and an institute in Texas. It appeared that service to him was uncoordinated (to say the least) and that the various service programs were saying, in effect, "This program doesn't have appropriate services, so let someone else take care of him." Meanwhile, no program adequately met his needs.

One 16-year-old runaway girl described as emotionally immature could not be successfully placed in a foster home and therefore was sent to a facility in Texas.

One 6-year-old emotionally disturbed hyperactive child repeatedly had failed foster home placements at age 4, had been placed on a mental retardation ward at NMHI for a while but was soon released as not being retarded, had been repeatedly rediagnosed due to failure of his records to follow him as he progressed through the system, and eventually was placed in a California facility.

We could go on and on, but the cases presented illustrate the pattern. It is a sad and distressing picture of young children bounced from agency to agency and finally out of state for service because: (1) appropriate services were not provided in Nevada before the need for residential mental health services arose; (2) various Nevada agencies took the stand that their programs were not appropriate for the provision of the residential services currently needed by the child; and (3) no one took the responsibility for creating or providing the services in Nevada. It is tragic that most seriously emotionally disturbed children must have remained unserved in Nevada, since only a fortunate few were sent for service elsewhere.

During FY 1974, there were usually 20 to 30 emotionally disturbed Nevada children placed in out-of-state institutions at any given time.⁵⁸ For example, at one point in FY 1974 four emotionally disturbed and mentally retarded youth were placed out of state, and another 20 emotionally disturbed youth were placed in out-of-state institutions by the Nevada Welfare Division at a typical cost of approximately \$800 to \$1000 a month. As of December 1975, the number of children placed out of state had grown to 45.⁵⁹ Assessment of the quality of services provided out of state were beyond the scope of this study. The CBS program in Las Vegas noted

is indeed responsible for the child. Welfare, however, apparently has not accepted this precedent and each case is fought. This legal wrangling between agencies is, of course, at government (i.e., taxpayer) expense. (Information provided by Frank Sullivan, Washoe County Department of Juvenile Probation, Reno, Nevada, September 1974.)

⁵⁸ Interview with G. Handley, Nevada Welfare Division, Carson City, Nevada, August 1974.

⁵⁹ Ibid. Placement was first sought at NMHI for mentally retarded youth before sending them out of state. December 1975 information was provided in a letter from W. J. LaBadie, Nevada Welfare Division, Carson City, Nevada, to J. S. Kakalik, The Rand Corporation, Santa Monica, California, March 3, 1976.

that 16 Clark County children who needed residential mental health services were in out-of-state institutions in late 1974.⁶⁰

In December 1975, the 45 children placed in out-of-state institutional care by the Nevada Welfare Division had the following characteristics. Seven were under 12 years of age; 12 were aged 12 to 14 years; and 26 were 15 years of age or older. Four were mentally retarded; 5 were emotionally disturbed and mentally retarded; 18 were emotionally disturbed; 3 were psychotic; one had delinquent behavior; and 14 were emotionally disturbed with delinquent behavior. Approximately half had had no prior institutional placement, but 9 had had 3 or more prior institutional placements. Eight had been in the current institutional placement for 0 to 6 months; 12 had been there 6 to 12 months; 16 had been there 1 to 2 years and 8 had been in the current institutional placement 2 years or more. The cost per month of each out-of-state placement ranges from \$450 up \$1500, depending on the child's needs and the institution; the average cost per month is about \$1000.

In recognition of their role in providing residential mental health services by default (since the Division of Mental Hygiene and Mental Retardation did not provide those services), staff members of the Nevada Welfare Division proposed that the legislature give them funds for construction of a residential treatment center for severely emotionally disturbed teenage children. We were told by a Welfare Division administrator that the proposal was meant only to call the legislature's attention to the lack of treatment facilities in the state and to the seriousness of this situation.

In addition, the Welfare Division staff has proposed asking for state monies to build two halfway houses for 20 emotionally disturbed children each (one in Las Vegas and the other in Reno), for children 16 years old and up. For the younger emotionally disturbed child, they propose to train and provide special foster care parents (see Chap. 13 for our recommendations regarding foster homes).

The Specialized Children's Services team [a welfare social worker and the foster home parents] will provide service to the emotionally disturbed child—ages 3 to 13—who are [sic] not severely physically handicapped or severely mentally retarded. These will be children who cannot function in a regular foster home setting and/or who are returning from institutional care or who may be potential for institutional care. The staff-child ratio will be on approximately one-to-one basis.⁶¹

To the extent that the new CBS and the Las Vegas Mental Health Center's residential treatment programs serve the types of children and youth that the Welfare Division staff would serve in their proposed programs, the problem is lessened. William LaBadie, of the Nevada Welfare Division, pointed out in a March 3, 1976 letter to The Rand Corporation that: "The problem is that the Division of Mental Hygiene and Mental Retardation views these residential facilities as only very short-term. Without some type of residential intermediate mental health facility, the state would continue to be faced with the problem we have presently. Not only would the number of children in out-of-state placement not be reduced with the increasing population, the numbers would be increased." In any event, we suggest that the direct provision of mental health and mental retardation services is not the most appropriate function of Welfare Division personnel.

⁶⁰ *The Executive Budget*, p. 326.

⁶¹ From a draft proposal, Nevada Welfare Division, Carson City, Nevada, undated (copy provided in 1974).

NEEDED IMPROVEMENTS: RESIDENTIAL MENTAL HEALTH SERVICES

Residential mental health services in Nevada are improving. The following recommendations are therefore intended not as criticisms of recent changes but as guidelines to further improvement. Three years ago, for children and youth with mental health problems, there were essentially no residential services in Nevada, but the legislature has since approved three major new programs providing relatively short-term services (the Las Vegas Mental Health Center and the two CBS programs); however, there is still a need for longer-term, in-state, intermediate levels of residential mental health services for children and youth. For adults, the NMHI, the prison, and a few local and private hospital beds existed three years ago, and the legislature since has approved two major new programs (the Mentally Disordered Offender Facility and the Las Vegas Mental Health Center adult programs); however, there is still a need for short-term residential capacity in conjunction with the two improved mental health centers we recommended in Chap. 8, and the recent massive shift of the mental health section of NMHI from chronic care toward short-term acute treatment has left those adults in need of intermediate level chronic care inadequately served.

The two newly approved CBS residential facilities help fill a gaping hole in the Nevada mental health residential service system for young people, and we fully endorse them. In 1974 there was no residential mental health treatment program for children and youth, either public or private, in northern Nevada. The only public mental health facility in the entire state accepting youth on a residential basis was the Las Vegas Mental Health Center, and it usually accepted only youth over 12 years old from the Las Vegas area. Consequently, 20 to 30 of those children with the severest mental health problems requiring residential treatment were sent to mental facilities out of state. (Forty-five were placed out of state in December 1975.) Other less fortunate children were not served at all. Still others ended up in places such as the state juvenile Training Centers or the state Children's Homes, which are not intended to offer mental health treatment programs.

When construction is completed on the CBS residential facilities in Reno and Las Vegas, this lack of residential mental health services for youngsters in Nevada will be partially rectified. However, the CBS program in the south accepts only 0-to-12-year-old children, while the Las Vegas Mental Health Center serves those over 12. If the CBS program in the north accepts only those less than 13 years old, there will still be no residential mental health program for children over 12 years old in northern Nevada. Also, both the northern and southern Nevada CBS residential programs will provide only short-term intensive residential services and short-term transitional residential placement with specially trained "professional parents." Any child who cannot live in his or her own home or in a foster home over the longer term will not have longer-term, in-state, intermediate levels of residential mental health services available (a subsequent recommendation deals with this problem). The emotionally disturbed children served by the Welfare Division represent a rather unique group of children. These are children who do not have parents or have been removed from the custody of their parents because of neglect, abuse, or abandonment. For many of these children, their natural parents either do not exist or their own problems are so severe that the family does not represent a placement resource to the child. Consequently, the child is not only in need of mental health

services but also is in need of a roof over his or her head. In addition, emotionally disturbed youth in rural areas need provision for residential services from the CBS or some other program and outpatient services from an upgraded Rural Clinics program. Finally, the CBS nonresidential program in Las Vegas currently does not provide a full range of treatment modalities to meet the range of children's needs; rather, it focuses primarily on the "behavior modification" treatment modality, as discussed in Chap. 8. *We recommend that the two CBS residential treatment programs be adequately and unconditionally staffed, specifically including positions for both physicians with training in psychiatry, and psychologists so that a broader range of treatment modalities can be provided; that the Reno CBS residential facility serve children and youth through age 18; and that both facilities combined accept rural children so that a difference in the level of service per capita does not exist between the Las Vegas, Reno, and rural areas of Nevada.*

Although the mental health section of NMHI is accredited, the facility's program still has major deficiencies that must be corrected to maintain accreditation. *We recommend correction of the major deficiencies noted in the JCAH accreditation report for the psychiatric section of the NMHI.*

A major problem exists with the quality and quantity of psychological services provided at NMHI. The psychiatrist in each NMHI neuropsychiatric unit is able to spend an average of only about one-half hour per week in direct contact time per patient exclusive of record-keeping (recall the median stay of 17 days). Other staff members therefore must carry a heavy responsibility for patient treatment. Since the units do not each have a direct-patient-services psychologist, and since the social worker has other responsibilities, the one supervisory psychiatric nurse and the unit's mental health technicians who are assigned as each patient's "primary therapist" must shoulder a heavy load. But the technician's job requires only a high school education, and at the time of our interviews their training was grossly inadequate; there was no formal training program for all the technicians at NMHI (contrary to the officially stated job requirements). Consequently, most of the mental health technicians, although hardworking and dedicated, are not skilled enough to adequately do the work they are responsible for. The upshot is that drugs appear to be the primary mode of treatment for most mental health patients at the Institute. However, psychopharmacological intervention is primarily useful as an adjunct to other kinds of treatment (e.g., psychotherapy) which it may facilitate but does not replace.

Essentially the same lack of skills and inadequate training of "technicians" prevails in the Las Vegas Mental Health Center residential treatment program, and in the state's other mental health centers and rural clinics mental health programs. Recently, some improvement has been made by the Rural Clinics program overfilling some of its technician positions with master's level professionals. The NMHI Director also told us he is "proceeding to replace mental health technicians with more highly skilled professionals." As of February 1976, the NMHI had converted 2½ such positions. To resolve this situation, *we recommend that the requirements for the job of mental health technician be upgraded to the master's degree level; that the University of Nevada create a new master's degree program in mental health; and that on-the-job training programs in the various mental health facilities be substantially upgraded.* The new master's degree program in mental health is detailed in Chap. 8, and provides a broad range of mental health service skills. Along with

upgrading the skills of mental health technicians, certain other changes are necessary: it must be recognized that technicians who serve mentally retarded people and those who serve people with mental health disorders need different skills. Moreover, much of the existing mental health technicians' work involves escorting people, doing housekeeping, and other tasks that should be assigned to people with lower skill levels, not to the proposed master's level technicians.

In addition to the deficiencies in mental health services within NMHI, noted above, another major deficiency of the NMHI mental health program in mid-1974 was in the area of postdischarge follow-up treatment. Continuity of care and adequate follow-up treatment after discharge from NMHI was the exception rather than the rule in 1974. This is a major problem with the state's mental health service system since two primary objectives of inpatient treatment are (1) to help the patient through a severe mental health crisis (a few days of treatment will usually help a patient past an episode of acute decompensation) and (2) to engage the patient in a treatment process which will be ongoing and which will address itself to the basic problems that made him or her vulnerable to the acute decompensation. Whereas the first objective can usually be satisfied in a brief hospitalization of a few days' duration, the second objective usually requires substantial treatment over a longer period of time extending beyond the period when hospitalization is required. Psychotherapeutic services, for example, usually cannot be satisfactorily completed within a 17-day period (the median NMHI length of stay). The Reno Mental Health Center's lack of adequate follow-up (other than drugs) in 1974 has led the NMHI to attempt its own follow-up in the Reno area, but the limited NMHI staff has enough difficulty merely providing its residential services. The Rural Clinics personnel were not providing adequate follow-up for most rural residents discharged from the Institute and it is doubtful that they have the personnel to do so and also fulfill their other responsibilities (see Chap. 8). For Clark County residents, the transition is abrupt from the Institute to Las Vegas Mental Health Center, but that center has the capacity to provide adequate follow-up services, and has recently developed an "Advocacy/Aftercare" program, which provides follow-up services to former inpatients of the Las Vegas MHC and NMHI, and generally monitors and implements continuity of care. *We recommend implementation of improved follow-up treatment to provide a continuity of care for mental health patients released from NMHI; mandatory improved follow-up procedures also should be established to help ensure that people released from other state-operated residential mental health programs (Las Vegas MHC and CBS programs) receive adequate follow-up services. This includes both short-term and long-term follow-up, e.g., for people who have a chronic need for some intermediate level of mental health services and are residing in extended care facilities that do not provide those services. The expanded mental health centers and rural clinics staff improvements we recommend in Chap. 8 are necessary to provide fully adequate follow-up treatment for NMHI ex-patients, since outpatient services are not in adequate supply and day-treatment services are nonexistent outside the Institute in most geographic areas (particularly in rural counties and Washoe County).*

Since changing a patient's primary therapist in the transition from residential to nonresidential service is difficult and can disrupt treatment, it ideally would be preferable to have the same primary therapist in both the inpatient and nonresidential phases of treatment. Professionals such as psychiatrists or Ph.D. level psycholo-

gists could be used as the single primary therapist in all phases of treatment. However, the new master's degree level of mental health service personnel we recommended above could be assigned the role of primary therapist (with appropriate professional supervision and support) and provide substantial meaningful treatment at relatively low cost compared with using only psychiatrists or Ph.D. level psychologists.

We reiterate from Chap. 8 our recommendation that two new *Community Mental Health Centers* be created, one in the Las Vegas area and one in the Reno area, with provision in each for short-term (a few days or weeks) inpatient treatment, as well as day and outpatient treatment. About 100 new bed-spaces will be required by 1985 merely to maintain the present level of residential mental health service capacity on a per capita basis in Nevada.

The Las Vegas Mental Health Center's residential treatment program had a number of problems in 1974, which we noted earlier. In our view, they stemmed from the newness and rapid startup of the program, from the fact that it was not yet fully professionally staffed when we interviewed, and from the low skills of the mental health technicians. Time and administrative attention should have taken care of the former two reasons by now, and the latter reason is the subject of our earlier recommendation regarding upgrading mental health technicians' skills throughout all programs.

A major problem with Nevada's mental health service system is the nearly total lack of intermediate services between full inpatient treatment and outpatient treatment. For example, service system capacity is lacking in the areas of halfway houses, day-treatment facilities, and chronic care programs that provide more than drugs. Most mental health care in Nevada today is episodic, and little or no intermediate level aftercare is provided following discharge from residential treatment. The lack of day-treatment facilities would be alleviated by the two new *Community Mental Health Centers* recommended above. Chronic care programs and halfway houses are discussed below.

A large remaining gap in the mental health service system is in service to people with chronic mental health problems. Ironically, this gap was created for adults only recently by an administrative policy shift in the type of residential service to be provided by the NMHI (from chronic and acute toward primarily short-term acute mental health service). In reducing the number of mental health residents at NMHI from about 380 to less than 100, long-term patients receiving chronic residential care were released to the care of their families or other residential facilities that usually have no mental health services (e.g., intermediate care facilities, nursing facilities, and adult group care facilities). Other than the prescription of drugs, periodic visits by an NMHI nurse to those other residential facilities, and psychiatric consultative services provided on request to three skilled nursing facilities in the Reno area, there is no follow-up. The follow-up has improved since 1974, but there is still a gap in the service system between the full intensive inpatient treatment NMHI is supposed to provide and care with "normal" people in nursing homes, group care homes, or with the person's family. A similar gap in services exists for children, as we discussed above in the section on the CBS residential programs. We recommend the creation of mental health service programs, for children and adults, providing an intermediate level of mental health services over an extended period of time to people with chronic mental health disorders. Both children and adults may need this type of extended-term intermediate level of mental health services, and

the service system should provide for serving people in both age groups in separate programs. This should not be a long term hospitalization or institutional program. It could be a program providing substantial outpatient, day treatment, and other services (as appropriate to the individuals' needs) for people residing in various types of supervised facilities in the community. This intermediate care program, discussed more fully earlier in this chapter, would provide some direct mental health services (more than drugs) and some of the residents would be free to move about in the community. The lack of such a program has resulted in some children and adults not being served, some people cycling from agency to agency (one such person reportedly cost the service system \$30,000 to \$40,000 in one year), and children being sent to institutions out-of-state.

Halfway houses provide a community-based intermediate level of residential service for short periods (weeks or months) for people released from residential intensive treatment programs but still incapable of living independently in the community. Halfway houses also provide an alternative to hospitalization. In 1974, we were aware of none in the entire state for people with mental health disorders, although some existed for alcohol and drug abusers (see Chap. 9) and for mentally retarded people (see Chap. 13). A small transitional facility is planned for the NMHI, but it can hardly be called community-based. *We recommend the creation of halfway houses operated in conjunction with mental health centers in both northern and southern Nevada for people with mental health disorders.* The mental health centers could provide substantial outpatient, day treatment, and other services (as appropriate to the individuals' needs) for people residing in these halfway houses. These halfway houses not only would provide a missing level of service and a means of avoiding unnecessary hospitalization or unnecessarily extended hospitalization, but also would be less expensive than full residential treatment programs.²²

We found conditions for mentally handicapped people at the Nevada State Prison in mid-1974 to be extremely bad. The state has recognized the severe problem of lack of psychiatric treatment for prisoners with mental health disorders, and has acted by beginning construction on the new 32-bed Mentally Disordered Offender Facility. We endorse this greatly needed new mental health program. However, the current number of Nevada prisoners in need of mental health services exceeds the bed-capacity of the Mentally Disordered Offender Facility, and the rapidly expanding population of the state is likely to be accompanied by a rising population of mentally handicapped prisoners. The courts recently ordered that certain types of prisoners be evacuated from the prison's "psychiatric unit," but most mentally ill prisoners were not on that unit at the Nevada State Prison. The stated intention of the Division of Mental Hygiene and Mental Retardation is to use the Mentally Disordered Offender Facility for treatment of a "relatively short-term nature" and then to return the individual to "his natural environment or the criminal justice system." Consequently, because of the small size of the Mentally Disordered Offender Facility, it is clear that at least follow-up mental health services will have to be

²² See R. M. Glasscote et al., *Halfway Houses for the Mentally Ill*, the Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, Washington, D.C., 1971; National Institute of Mental Health, *Half-way Houses Serving the Mentally Ill and Alcoholics, United States, 1969-1970*, Mental Health Statistics Report Series A, No. 9, Publication No. (HSM) 72-9049, U.S. Government Printing Office, Washington, D.C., 1971; and L. Ozarin and M. Witkin, "Halfway Houses for the Mentally Ill and Alcoholics, a 1973 Survey," *Hospital and Community Psychiatry*, Vol. 26, No. 2, February 1975.

provided to some people who are returned to the Nevada State Prison following intensive treatment at the new facility. In a March 4, 1976 letter to Rand, the Clinical Director of the new facility, Robert Hillan, acknowledged that "it is quite obvious that we cannot handle all of the mental health problems (broadly defined) of the State Prison." The facility's small size is acceptable, provided the rest of the mental health service system operates appropriately. If all prisoners with mental health problems are to receive the services they need, we believe it essential to implement the following three recommendations.

We recommend that the Mentally Disordered Offender Facility be used primarily for treatment of prisoners with mental health disorders, and not for persons who have neither been charged with nor convicted of crimes but who need treatment in a secure facility.

We recommend that provision be made for mental health services within the Nevada State Prison for mentally disordered prisoners who do not need the intensive level of treatment provided by the Mentally Disordered Offender Facility, or who need follow-up services after intensive treatment at that facility. Providing services at the new facility will solve only part of the problem; there should be no false impression that a new small facility can furnish adequate services to all mentally ill prisoners. To provide those services within the prison, additional mental health staff positions will be required; we suggest that those staff members be under the direct supervision of the administrator of the Mentally Disordered Offender Facility rather than under the sole supervision of the warden.

We recommend that the Nevada Mental Health Institute accept responsibility for providing a secure neuropsychiatric unit for those patients who need it and have not been charged with or convicted of crimes. While drugs and other therapy have in most cases eliminated the need for physical restraints at the Institute, some patients need a locked unit or area where they can be monitored to help prevent them from physically abusing themselves or other patients, and to restrain them from leaving the Institute. The Mentally Disordered Offender Facility already has more than enough responsibility and should not have to serve patients the Institute could adequately serve.

The median length of stay for discharged NMHI mental health patients was about 17 days in 1975. In those terms at least, the Institute is now primarily functioning much the same as the inpatient units at Washoe Medical Center, Southern Nevada Memorial Hospital, and the Las Vegas Mental Health Center. The Institute currently is not functioning primarily as a place for treatment of patients needing more prolonged care than that typically provided by those three mentioned community-based facilities.

Having described problems with the various residential mental health service programs and made some recommendations for improvement, we can now summarize what we believe to be the most appropriate functions for the NMHI. *We recommend that the mental health section of the Nevada Mental Health Institute concentrate on inpatient mental health treatment for rural Nevadans, for those who need a secure facility, for those who need more than short-term residential treatment at the mental health centers, and for those unable to enter the inpatient units of mental health centers because they are temporarily filled to capacity. Thus, we see the mental health section of the current NMHI facility as complementing the state's community mental health centers in the overall service system, rather than acting as a*

community mental health center itself (although the recommended new Reno area community mental health center might be located at or near the Institute). Each of the four service functions mentioned in the above recommendations for NMHI is essential and is not now being filled adequately by the state's mental health centers. Of course, one could define other functions for the soon-to-be-improved Institute facilities, but some other facility or facilities would still have to provide the four service functions we outlined for NMHI. The Las Vegas Mental Health Center does not have the bed-capacity to provide both short-term and longer-term residential services (by longer term we mean here 3 to 12 months, only occasionally more); the Institute has a larger capacity and a secure facility capacity, which it would seem wasteful not to use since funds for new construction are very limited. One could also recommend a second Nevada Mental Health Institute in southern Nevada; while that may be justified at some future point in Nevada's population growth, it seems unnecessarily expensive now in relation to other needs.

Given the current sparse populations in rural areas of Nevada, no single rural area currently appears capable of fully using an intensive inpatient mental health treatment facility. We believe that rural Nevadans can be more effectively and less expensively provided with intensive residential mental health services in one of the urban areas. Provision should be made to assure rural Nevadans of access to those services, including transportation to urban areas if required. Rather than have rural Nevadans compete with urban Nevadans for available bed-spaces in each of the mental health centers, it may be preferable to designate one facility to be responsible for residential mental health services to rural Nevadans. We suggest the Institute be so designated, since the only existing mental health center with residential capability already is supposed to serve the half of the state's population concentrated in the Las Vegas area.

We strongly urge responsible officials to take positive steps to coordinate the mental health operations of the various elements of the mental health service system. The need to monitor and coordinate the flow of people through the mental health service system is clear when one considers the current lack of referrals, and the lack of follow-up that pervades the service system. We reiterate our recommendation for the creation of Regional Direction Centers to provide needed coordination (see Chap. 4).

Finally, program management information being deficient, *we recommend that an improved information system be established for monitoring and managing mental health program operations, as well as the effectiveness of services.* Details of information deficiency were described earlier in this chapter, and also in Chaps 4 and 8.

NEVADA MENTAL HEALTH INSTITUTE: MENTAL RETARDATION PROGRAM

The Institute primarily provides longer-term residential care, treatment, and training for mentally retarded persons who are incapable (or not yet capable) of functioning in a less restrictive environment.⁴³ However, judging from our observa-

⁴³ Information in this section is based on several interviews in 1974 with mentally retarded residents of the Institute; Dr. V. LoCicero, Institute Director; D. Davis, D. Edwards, and J. Gray, each of whom has been Clinic Administrator for Mental Retardation (or acting in that position as head of MR programs

tions and the opinions of several staff members we spoke with at the Institute, a significant portion of the mentally retarded residents appeared to be capable of living in a less dependent setting if they were given adequate training, some community-based services, and the opportunity. A recent Nevada Department of Human Resources deinstitutionalization study concluded that about 30 to 40 of the current mentally retarded residents of the NMHI "require continued intensive life maintenance care."⁶⁴ As of February 1976, there were 108 persons in the NMHI mental retardation program, and there had been 39 discharges and 8 admissions since mid-1974.

Since 1974, the NMHI's mental retardation program has made several internal changes that have changed the quality and quantity of services provided for the current residential population. These changes have been implemented using the JCAH accreditation standards as a guide and are seen by NMHI only as beginning steps that are necessary to ultimately bring the residential program into compliance with accreditation standards. An attachment to a letter from NMHI Director T. Piepmeyer to Rand on February 27, 1976 stated, "these program changes are pitifully inadequate unless additional resources outside the existing program are obtained in the form of staff, training and proper mix of professional skills." The NMHI mental retardation program also has identified a program goal for a specific population it feels it can reasonably serve at this time, given available resources. This goal is for:

NMHI-MR to change the major focus of the NMHI-MR program from a custodial long term residential program to a shorter term, residential and day training oriented service for profoundly and severely retarded persons and their families residing in the northern area of the state by January, 1977.

The 1974 cost per day per mentally retarded resident at the NMHI was approximately \$33, or about \$12,000 per year per resident, using the Institute's method of allocating costs among residents.

Admissions of mentally retarded people to the Institute are handled by Interdisciplinary Committees of the Division of Mental Hygiene and Mental Retardation. The committees are described in the section of this chapter on the two mental retardation centers, whose admissions those committees also handle. After admission an interdisciplinary team plans the individual's program. The interdisciplinary team consists of the NMHI mental retardation administrator, a nurse, a social worker, an occupational therapist, a physical therapist, a vocational rehabilitation counselor, a speech therapist and direct residential care staff (and when appropriate, a psychologist, a dietitian, a chaplain, a pharmacist, a physician, and/or a special education teacher if the person is between the ages of 3 and 18). Other disciplines (e.g., dentist) and referral agencies (e.g., the Washoe Association for Retarded Citizens) are included in this group when appropriate. This interdisciplinary team serves as both a review team for individual client programs on a continual review schedule and as an initial evaluation team for newly admitted clients. The team is

at the Institute) in 1973 or 1974; H. Robert Quilitch, the chief psychologist at the Institute; numerous Institute staff members serving mentally retarded people; and a letter from T. Piepmeyer, NMHI, Sparks, Nevada, to J. S. Kakalik, The Rand Corporation, Santa Monica, California, February 27, 1976.

⁶⁴ Developmental Disabilities Council, *Deinstitutionalization Plan—State of Nevada—Developmental Disabilities*, Department of Human Resources, Carson City, Nevada, 1974.

responsible for performing all of the tasks identified in the JCAH standards that deal with interdisciplinary teams, including the identification of long and short range placement needs, protection of legal and human rights, etc. This team has been functioning since March 1975. As of February 1976, 86 clients have been reviewed, individual client needs identified and a corresponding treatment/training plan developed. According to an NMHI administrator, about 50 percent of the activities identified in these plans have been deferred due to inadequate staff. The deferment of needed activities is seen by NMHI staff as discouraging but it is perceived as a tool to identify more accurately the kind and number of staff required and to further identify staff training needs.

About 43 percent of the mentally retarded residents of the Institute are from Clark County (which has about 56 percent of the Nevada population), 34 percent are from Washoe County (which has about 24 percent of the state's population), and 23 percent are from the remaining primarily rural counties (which have about 19 percent of the state's population). As of June 1974, the median length of stay for retarded residents at the Institute was about 10 years; 49 percent had been there over 10 years, while only 23 percent had been there less than 5 years, and only one percent less than one year. About 55 percent of the NMHI mentally retarded residents were 18 years of age or over in 1974; only 2 percent were less than 5 years old.⁶⁶

The Institute's psychologist has conducted a study of mentally retarded resident activity.⁶⁶ Residents were observed over a period of weeks at random times between the hours of 9 a.m. and 11 a.m. each day. A resident was counted as active "if he is doing a chore, grooming himself, reading or writing, conversing with another person, or using recreational materials." Of the 95 residents on Wards 1 through 4 at the time of the study, the daily average number of active persons was 6 prior to the time attempts were made to induce the ward staff to increase activities. First, a memo was sent instructing all staff members to lead daily activities, and some days later a short workshop was conducted to teach them how to do so. Several more days later, specific staff members were assigned to be activity leaders, and performance feedback was provided by posting the daily average number of active residents on each ward. The study found that "Neither the memo nor the workshops motivated staff to lead activities, but after staff were scheduled to lead activities and given performance feedback the average daily number of residents engaged in activities on four wards for 95 retarded persons increased from 7 to 32." The author of the study indicated to us that when the experimental scheduling and staff performance feedback was stopped, activity returned to its previous low level. However, the most important observation is that during prime hours for activity (9 A.M. to 11 A.M.) only 7 of the residents were active on the average. The rest were "... usually napping, staring, rocking, pacing, or engaged in stereotypies."⁶⁷

Another study was conducted on ward 5, which had about 25 residents. A demonstration program was created to measure purposeful activities of residents and to teach staff to lead activities. Prior to the demonstration, observations were made at

⁶⁶ Data in this paragraph are taken from *Rehabilitation Facility Plan, 1975-80*, Rehabilitation Division, Nevada Department of Human Resources, Carson City, Nevada, January 1, 1975.

⁶⁷ H. Robert Quilitch, "A Comparison of Three Staff Management Procedures," *Journal of Applied Behavior Analysis*, 1975, Vol. 8, pp. 59-66.

⁶⁸ Ibid. Stereotypy is defined as the frequent and almost mechanical repetition of the same posture, movement, or form of speech.

half-hour intervals from 8 A.M. to 4 P.M. for several days. It was found that the average number of residents engaged in purposeful activity ranged from one to two. It also was found that when the planned activities were instituted, this figure quickly rose to an average of 12 residents. After the demonstration program was stopped, it was found that the average number of residents engaged in purposeful activity "dropped to zero."⁸⁸

According to the NMHI psychologist, the staff incentive structure needs to be changed.⁸⁹ He said the staff realizes that people visiting the NMHI can see the cleanliness and orderliness there, and the staff know that they are more likely to be criticized for lack of cleanliness and order on the ward than they are for inactivity of residents. Also, NMHI is inspected at random times by Health Division personnel who have the power to order correction of "cleanliness" deficits.

To begin to resolve the problem of lack of resident activity and training, a new Day Training Center has been created in one building at the NMHI, using existing mental retardation unit staff. Unit staff accompany a small number of clients (5-10) from their unit to the Day Training Center. In the Center, both the staff and the clients are assigned specific activities; the staff are consistently assigned to the same clients. Clients are involved in either one-to-one or small group training activities that are in keeping with the client's skill deficits. The supervision of these activities and the curriculum have been developed by a staff member who has formal educational preparation and has served a one year internship under the NMHI Psychologist. A second feature of the center is that the staff receive on the spot training and immediate feedback from the supervisor of the Center. However, the primary focus is on the client's training and staff's interaction with the client. The schedule has been coordinated so that the client attends the Day Training Center during those periods of the day when there are no other scheduled activities for him or her. The Center is then supplemental to other activities such as school, occupational therapy, physical therapy, etc., and is alleviating "dead time" on the units.

According to NMHI administrators, this program is only embryonic at present, convening 5 days per week from 8:00 A.M. until 5:00 P.M. The program administration has been actively pursuing additional sources of funding for the program. If additional staff can be obtained, this program can be offered to severely and profoundly retarded persons living in the community as an extension of their present activities. It could be available 7 days per week, 16 hours per day. As more clients are placed in living environments outside of the Institute, but in the general area of Reno/Sparks, they could continue to utilize the service. The longer range NMHI plan would place this day training center for severely and profoundly retarded persons in a community setting away from the NMHI grounds.

During our visits to the Institute, we were struck by how few mentally retarded persons there were outside of the wards, even in midmorning and midafternoon on beautiful spring and summer days. Outdoor recreation facilities seemed to be used but little. On the baseball diamond the grass between home plate and first base was growing as vigorously as it did in the outfield, and the weeds under the monkey bars in the play area were a foot high and untrampled. In the summer, retarded residents are allowed outside on the grounds (although on all but one ward they must be

⁸⁸ H. Robert Quilitch and J. Gray, "Purposeful Activity for the PMR: A Demonstration Project," *Mental Retardation*, December 1974, pp. 28-29.

⁸⁹ Interview with H. Robert Quilitch, NMHI, Sparks, Nevada, November 15, 1974.

escorted by staff), but in the winter they are kept inside on the orders of an Institute medical doctor. When asked why retarded residents were not escorted off the wards more often, ward technicians said they were too busy. The director of recreation therapy for the Institute also indicated that retarded residents do not come because the locked wards lack staff to escort them.

Retarded residents do very little work. In mid-1974, five of the 140 retarded residents worked in paid "industrial therapy" jobs at the Institute, and seven participated in a sheltered workshop in Reno. Two portions of the Institute—the laundry and the kitchen—that could be used for industrial therapy to build vocational skills of residents and thus facilitate deinstitutionalization, reportedly did not accept mentally retarded workers.

About two-thirds of the retarded residents of the Institute were on what the MR administrator called "control" drugs (not including antispastic or anticonvulsive drugs). The general practitioner physician specified the type of drug and dosage. The nursing staff supervised the administration of the drugs and told the physician if they thought the drug or dosage needed changing. Basically, we were told the nurses interact with the residents regularly, and the physician usually sees a resident only if he or she is sick or needs an annual physical. The physician, however, must sign each resident's chart monthly. At the time one of Rand's physician-consultants visited the MR wards, three residents had what might have been major Thorazine reactions. Medical supervision of residents appeared to be minimal. The special education teachers at NMHI alleged that not all the young residents they served had had hearing or vision tests, and that at least one child had not received needed glasses.⁷⁰ The rather extensive use of drugs, and what appeared to be relatively minimal medical supervision of retarded residents, is probably an additional manifestation of the small staff size.

Psychological counseling or psychiatric services are not regularly provided directly to mentally retarded residents of the Institute, not even to those with mental health problems. Institute psychiatrists do not work with any retarded residents. The one full-time psychologist, who must serve the *entire* Institute, not just the mental retardation section, attempts to help other staff members help residents since he has insufficient time to help the residents directly. The psychologist recently helped set up a toilet training program, reportedly spends 5 to 10 hours per month counseling staff members on how to help individual residents, and directly served one resident in 1974. (An aversion-therapy behavior modification program—in this case employing a cattle prod—was used on a resident who was physically abusive of herself and others). More recently, the psychologist has led problem solving groups for ward 4 residents.

At the time of our visits, each of the five NMHI Mental Retardation wards was staffed during the day with three or four "technicians," including a supervisor, who typically have no prior training in working with mentally retarded people. The evening and night shifts have one or two such technicians. The technicians are assisted professionally by one clinic administrator, who is in charge of all MR activities at the Institute, only one social worker, and five special education teachers (beginning only in 1973 and serving only residents aged 18 or less). Since 1974, one technician position has been reclassified to a master's level social worker position; the current two social workers also have 1½ full-time-equivalent staff assistants.

⁷⁰ Interview, November 22, 1974.

The technicians also receive part-time assistance from the following types of personnel, who also serve MNHI's geriatric and neuropsychiatric residents: one medical doctor, one psychologist, one physical therapist, occupational and recreational therapists, and nine Institute nurses. Two of the wards also benefit from several half-time "foster grandparents" (who outnumber the regular staff on those wards during the day). Thus, the 1974 direct-service staffing for the 140 residents numbered about 25 to 30 full-time-equivalents on the day shift and 5 to 10 on the evening and night shifts. The total direct-service staff for mentally retarded residents is 65. This level of staffing is clearly insufficient to provide adequate services and programming for the residents, as attested to by the JCAH non-accreditation rating as a facility for mentally retarded people. Full details of that non-accreditation rating are discussed later in this chapter and in App. B. The administration of the MR section of the NMHI clearly recognizes and acknowledges the deficiency in the level of staff, and requested a total of 72 new staff members prior to the 1975 legislative session. Before that request left the Division of Mental Hygiene and Mental Retardation, it reportedly had been pared by higher-level administrators of the division from 72 to 3½ new staff members for the mental retardation section of NMHI. The Governor's office subsequently cut the request even further, and recommended that the legislature fund only three new staff members for the entire Institute (including the alcohol and drug abuse, mental health, and mental retardation sections).

The Institute's medical director⁷¹ indicated to us that he would much prefer asking the legislature for the total staff needed, so that legislators will vote on staffing with full knowledge of the need, but he said he is not allowed to do so. The insufficient staff situation in the mental retardation section of the Institute was described in more graphic terms by that section's administrators:

"We're keeping the pants dry and puddles off the floor."

"We couldn't function without foster grandparents." "On days when they're not here [the foster grandparents], I'm not sure they [the residents on Ward 1] get three meals a day."

"[A program for an individual is] a euphemism here." "[We have] the ability to design a beautiful program but don't have the people to implement it. . . . A small percent are being given a real program."

"[More staff is needed because] we in essence teach abnormal behavior in this environment."

The orientation and training program for new staff members ("technicians") of the MR section of the Institute is two weeks in duration (as of 1974). During the first week the new staff member spends half the time in class and half the time observing other staff members. Class time is primarily devoted to administrative matters and is reportedly administration and maintenance oriented, not service oriented. However, a library is maintained for new staff members and one videotape training aid ("The Dentist") had been prepared. The second week of orientation finds a new staff member working on all five wards and on all shifts, on a rotating basis. By the third week on the job, the new staff member is working at his or her regular assignment. The greatest deficiency in training new staff members was in teaching them how to train residents and help them develop their functional abilities. Ongoing on-the-job

⁷¹ Interview with Dr. V. LoCicero, August 20, 1974.

training for staff members was mostly not training-oriented either; it covered such subjects as safety, record-keeping and charting, and dental care. Approximately two hours per month of ongoing training were available to each employee, but attendance was not mandatory. As of June 1975, the toilet training program mentioned earlier involved the instruction of three staff members for from 40 to 80 hours in how to train the residents.⁷³ The new day training center for residents currently provides some opportunity for on-the-job training of staff members. Still, the level of staffing is inadequate, and technicians are not adequately trained to fulfill their program responsibilities.

The Institute's director was aware of the problem of the lack of staff training; he frankly admitted, "We don't have adequately trained staff."⁷⁴ Note that the training provided is significantly less than what is officially required for mental health technicians (see above, "NMHI: Mental Health Program").

Supervision of existing staff appears to be minimal. The administrator of the MR section is the supervisor of the ward managers, but indicated there is not enough time to really be on the wards and see what is happening, and therefore "the ward manager is pretty much on his own."

Description of NMHI Mental Retardation Wards

This section describes the mental retardation wards as they existed in mid-1974. Since that time the living units have been reorganized. There are currently four residential units, and an NMHI administrator indicated that this relocation has not necessarily improved clients' living quarters, but it has facilitated better utilization of direct care staff. The new units are organized as follows: Unit A is for 22 people who are at a non-ambulatory profound retardation level of functioning (see the AAMD definition in Chap. 3) and have restricted mobility; Unit B is for 20 people who are independently mobile, have limited aggression, have the beginning of self-help skills, and are of small stature; Unit C is for 33 people with a profound to severely retarded level of functioning who are independently mobile and have limited self-help skills; Unit D is for 33 people who are responsibly mobile, have independent self-help skills, and severe to lower range of moderate retardation.

MR Ward 1. In August 1974, this ward had 34 nonambulatory severely and profoundly retarded residents who, typically, also were physically handicapped. The age range was 3 to 28 years, but only two residents were over age 21.

The technician staff devoted about an hour a day to activity (such as playing with a ball or finger painting) other than feeding, changing diapers, and dressing the residents. The day-shift technicians reported spending about 6½ hours out of 8 in merely feeding the residents. The ward staff indicated they were very dependent on the foster grandparents who assist on the ward.

The Institute's Clinic Administrator for Mental Retardation indicated that some of the nonambulatory residents on Ward 1 might become ambulatory if they received orthopedic surgery for uncorrected problems. However, such surgery is classed as "elective," and neither the Institute nor the Crippled Children's Service (see the medical services chapter of this report) had funded such surgery for all mentally retarded people who reportedly need it. There were also said to be very few

⁷³ H. Robert Quilitch, NMHI, Sparks, Nevada, as reported in *Nevada State Journal*, June 5, 1975.

⁷⁴ Interview with Dr. V. LoCicero, August 20, 1974.

funds available for prosthetic and orthotic devices. A local man repaired existing devices free of charge for the state-funded Institute.⁷⁴

Equipment was very scarce on the ward. Even the wheelchairs were purchased by private groups. The playground equipment consisted only of sewer tiles and rubber balls.⁷⁵

MR Ward 2. In August 1974, most of the 21 residents of this ward, aged 3 to 17, were ambulatory. The program emphasis on the ward staff was on training in self-help skills. All ward residents also were eligible for special education and training from the Washoe County School District with partial state financial support, and all but two were served for up to 5 hours each school day. However, the state did not provide the school district with enough teachers to serve all residents of ward 2. In fact, nearly half of the mentally retarded residents eligible for special education and training at the Institute were not receiving it, because of lack of funding for staff (see Chap. 7 on special education and training for details and our recommendations).

The atmosphere on ward 2, the Institute's "showcase" ward, was markedly better than that on the other four wards. Many playthings and personal possessions were in evidence, a stereo was playing, the walls were gaily decorated, the door to the well-equipped fenced play yard was open, and staff members and foster grandparents were working actively with the children on each of our three visits. This ward was the most pleasant and homelike; when we asked why it was physically different from the others, we were told that the facility and play yard were fixed up with volunteer and ward-staff work and funds, rather than the Institute facility improvement staff and funds.

Ten foster grandparents were assigned to this ward. Children were outside 3½ hours a day (*much* longer than in any other ward), and the ward 2 playground had adequate equipment. During meals some children received training in how to feed themselves, and we also noted walking and grooming training in progress. We contrast this ward with wards 3 and 5, where we saw no staff members working with residents to improve their functional skills on any of our three or four visits to those wards. On Ward 2, other activities included one hour of guitar playing and singing daily, plus a field trip each week to such places as a petting zoo. A physical therapist came to the ward one half-day a week and concentrated on teaching the ward staff and foster grandparents how to provide physical therapy for the children. The programming for the children on this ward appeared to be much more adequate than that for residents on the other wards.

MR Ward 3.⁷⁶ This locked ward was home for 24 retarded people aged 13 to 31 years in August 1974. These were mostly long-term Institute residents. One group on the ward (approximately 7 people) function as mentally retarded people but we were told they were childhood schizophrenics who were "not mentally retarded as children, according to the records," and were not receiving any psychiatric services in 1974. This may be one tragic consequence of inadequate service in the past, and the deficiencies in service to Nevada children with mental health problems still persist. A second group of residents on the ward consisted of ambulatory but abusive patients. The treatment program on this ward was described as "primarily chemoth-

⁷⁴ Interview with D. Davis, Clinic Administrator for Mental Retardation, NMHI, Sparks, Nevada, August 20, 1974.

⁷⁵ Ibid.

⁷⁶ Interviews with D. Davis and D. Edwards.

erapy" with "a little" use of behavior modification techniques. All but two of the residents were on psychotropic drugs (not including antispastic or anticonvulsive drugs).

Activities on ward 3 included a one-hour bus ride for all residents once every two weeks; a visit to the canteen for about four residents daily; one hour of arts and crafts (occupational therapy) for about ten people once a week; use of the play yard, typically once every two days for an hour or two; playing of records two or three times a week; and swimming twice a week in the summer. On days when those activities were not going on, an hour of puzzles and games was typical.

Four residents were receiving toilet training (a newly instituted training program) at the time of our visits, and in the course of getting residents dressed and feeding them, some minimal training in those skills was provided.

The list of activities described may sound impressive until one realizes that, aside from the custodial services of keeping residents dressed and fed and giving them a place to sleep, the NMHI provided ward 3 residents at most with only an hour or two of meaningful activity each day. The rest of the time was spent on a locked sterile ward with almost no personal possessions.

In August 1974 this ward and ward 5 were little better than human warehouses. When asked, the Institute staff could in honesty say they had many different programs and activities for these residents, but in reality the residents were exposed to those programs and activities only for short and infrequent time periods.

MR Ward 4. This 34-bed unlocked ward served two different groups of people. Approximately half were higher-functioning adults, all of whom had self-help skills and were sent by Institute bus to a local sheltered workshop or to independent jobs. Clearly, not all of them needed to live in the Institute; some should have been transferred out as soon as space could be made available in the mental retardation centers. Ward staff members we interviewed also felt that many of the residents of this ward could leave the Institute permanently if they had someplace to go. The two primary factors delaying deinstitutionalization of these people appeared to be the lack of adequate special education and training for them (see Chap. 7), and the lack of space in the MR Centers due to a lack of funding for more developmental homes in the community (see Chap. 13). The second major group of people on this ward consisted of ambulatory adult retarded persons who were functioning at a prevocational level. Psychotropic drugs were provided to about one-third of the residents of this ward. Personal possessions and recreational materials were in evidence here, but the relatively sterile institutional atmosphere was still predominant.

Activities for residents of this ward included working half-time at jobs within the Institute (3 people are on this "industrial therapy" program); attendance full-time at the Washoe Association for Retarded Citizens work activity center and sheltered workshop in Reno (7 people—see Chap. 11 for a description of the program); recreational therapy (about 2 people per day); swimming in the summer (approximately 8 people per day); bus rides (about 10 people for one hour once every 2 weeks); overnight passes or home visits (1 or 2 people a week); passes for shopping trips (about 6 people a week); dancing lessons at Arthur Murray's (4 people); a dance at the Institute about once a week (all residents); arts and crafts once or twice a week (all residents as a group); and a movie once a week at the Institute (about 20 residents).

Despite the fact that this ward had the highest-functioning adolescent and adult residents at the Institute, and the Institute's goal was to release many of them into a less dependent living arrangement, none of the residents received special education. The reason was that all are over age 18 and hence beyond the age range served by the special teachers at the Institute, even though they needed extensive special education and training to facilitate the deinstitutionalization goal.

The ward staffers also indicated that "male-female acting out" (sex) was a problem. According to them, Institute policy is to "ignore" sexual activity between consenting older retarded residents that did not take place in an open area; however, it is very strongly discouraged by the manager on the ward. All females received birth control services, but no residents received sex education despite the fact that this ward had the highest-functioning residents of all five wards and many were leaving the Institute on a day or overnight basis, or would soon leave the Institute for less restricted living arrangements. The Vocational Rehabilitation program was serving only two residents in mid-1974. Although the ward manager felt that all could benefit from the sheltered workshop and training provided by the Washoe Association for Retarded Citizens, not all the residents were in that program, reportedly because it was operating at the maximum client capacity allowed under Community Training Center rules (a maximum client-to-staff ratio of 5 to 1 was set for the CTC program by the Division of Mental Hygiene and Mental Retardation), and the WARC had no more Community Training Center funds from the division to hire more staff. The WARC also did not have facility space to greatly expand its services. Again, we see the phenomenon of a good program so seriously underfunded that it could not provide service for many people in need.

MR Ward 5. This locked ward was "home" for 29 ambulatory severely and profoundly retarded people aged 16 to 55 years. Their average stay at the Institute had been 12 years. Residents were mentally retarded, autistic, or functionally retarded childhood schizophrenics. All but two could feed themselves, four were being toilet-trained, and six were regularly engaged in arts and crafts (occupational therapy). Only two were allowed to leave the ward unescorted. All the rest were said to be on tranquilizing medication. Residents had access to a fenced play area and a pool during certain hours of the week. The pool was above ground. It was used only during the summer and was shared by all retarded residents of the Institute.

When we visited the ward unescorted and unannounced, we found all the bedrooms locked and the residents sitting in or milling around the very sterile commons room. No activities or personal possessions were in evidence. The staff members were closeted in their office. Our later visits did not dispel our initial impression of bleakness. Striving to find something positive to say about this ward, about the best we can do is note that it was clean and the residents were up, clothed, clean, and dry. The two staff members in charge of all mental retardation programs at the Institute agreed that "there is nothing going on up there."⁷⁷ There was about one hour of activity in the morning and typically a walk in the evening during nice weather.

Foster Grandparent Program

The federally supported foster grandparent program expended about \$143,000

⁷⁷ Ibid.

in FY 1975 to provide retired citizens aged 60 and over with half-time jobs working with mentally retarded children up to age 18. The number of people employed was expanded from about 60 in 1974 to 88 in 1975 with state funds supplied by the 1975 session of the Nevada Legislature.⁷⁸ They are employed at NMHI's Mental Retardation Section (35 foster grandparents), the Northern and Southern Nevada Mental Retardation Centers (5 and 8, respectively), several Community Training Centers (4 in Carson City, 4 in Hawthorne, 4 in Elko, 6 in the Washoe Association for Retarded Citizens Center), and in other public and private facilities for children such as the Special Children's Clinic, Head Start, and other nursery schools. In addition to their direct pay, foster grandparents receive annual physical examinations, and a meal each day at most of the facilities to which they are assigned. Each foster grandparent receives initial orientation and training, which lasts about 40 hours.

Regarding the value of these employees, we note that on four separate occasions, staff members of the basically staff-starved MR section of the NMHI told us that the foster grandparents were greatly needed and appreciated (e.g., one told us "the hospital couldn't function without them"). In two places, however (one of the state mental retardation centers and one of the community training centers), we were told that the foster grandparents gave a little too much tender loving care and should be more insistent that the retarded children learn to do things for themselves. This slight difficulty, if it exists in more than a few isolated cases, might be remedied by more or different training and supervision.

Community Placement Grant

The NMHI was recently awarded a \$65,000 grant for a project entitled "Community Placement of the Severely Retarded" by the Social and Rehabilitation Service of the U.S. Department of Health, Education, and Welfare.⁷⁹ According to the grant proposal:

The objective of this proposal is to generate a community group home for severely handicapped institutional residents, with accompanying programs. The following elements are proposed:

- Establish a group home in Washoe County, Nevada housing 8-10 severely mentally retarded persons now in residence at the Nevada Mental Health Institute.
- In addition to regular and relief houseparents the home will have a program specialist. This position will be responsible to provide appropriate activities and to recruit, develop, and coordinate volunteer and community program resources.
- Program support will also be provided from 2 one-half time Public Service Interns recruited from the University of Nevada. Another one-half time Public Service Intern, paid for through state funds, will be assigned 100% to this project.
- Project coordination will be provided by Ms. D. Davis with training and evaluation supervision under the direction of Dr. L. L. Beermann. Overall project direction will be the responsibility of Dr. T. Piepmeyer.

⁷⁸ Interview with J. Middleton, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, August 5, 1975.

⁷⁹ Ibid., August 6, 1975.

From the project goals and tasks, it appears that this activity would be most appropriately conducted by the Northern Nevada Mental Retardation Center. The center already has the expertise, and is responsible for developmental homes in northern Nevada and for service programs to people in the transition stage between needing full inpatient NMHI service and sheltered living in the community. With the Institute's program for mentally retarded people as deficient as it is, it makes little sense for the Institute to take on new and different responsibilities that greatly overlap those of the Mental Retardation Center.

Computerized Individual Client Data Base

During 1974 the Division of Mental Hygiene and Mental Retardation began to use a computerized, individualized data base for mentally retarded clients of division programs. This data base, developed in and using a computer in Pomona, California,⁸⁰ is sufficiently detailed to provide not only data and reports on clients or groups of clients and the services they are receiving, but also information on clients' functional abilities that could be used for program evaluation. In mid-1974, this data system had at least partial information on over 375 mentally retarded clients of the division. This computerized data base appears highly desirable in theory, and we endorse it or one with similar objectives tailored specifically to Nevada's needs. Two improvements would be desirable, however. First, to be of most value in seeing that mentally retarded people throughout Nevada get all types of services they need, the data base should not be limited to Division of Mental Hygiene and Mental Retardation clients, but should also include retarded people served by other programs, e.g., Department of Education, Division of Health, Division of Welfare, and Division of Rehabilitation. Second, the mid-1974 plan was to use a computer in Pomona, California, with information transferred by mail. It would be desirable eventually to have the data base on a Nevada computer, where it can be used more readily and can be tailored to Nevada's needs. The data base should be associated with the Regional Direction Centers we recommend in Chap. 4, if those centers are created.

Non-accreditation of the NMHI Mental Retardation Program

Despite public claims to the contrary by the Division of Mental Hygiene and Mental Retardation, which may be one reason the Nevada Legislature has not provided adequate staffing and funds, the NMHI is not "fully accredited by the national Joint Commission on Accreditation of Hospitals . . . for mentally retarded persons . . ."⁸¹ The Institute is accredited as a psychiatric facility by JCAH, but failed to receive accreditation as a facility for mentally retarded people in both 1974 and 1975. Both the 1974 and 1975 JCAH non-accreditation reports are presented in App. B. In summary, the following were *some* of the Institute deficiencies in the category of mental retardation in 1974:

- Staffing of the facility should be sufficient, so that the facility is not dependent upon the use of residents, volunteers, or foster grandparents for productive services.

⁸⁰ See *Individualized Data Base—Manual of Reports*, Neuropsychiatric Institute—Pacific State Hospital Research Group, IDB Publication Series, No. 5, Pomona, California, January 1974.

⁸¹ "Nevada's Mental Health and Mental Retardation Services," Division of Mental Hygiene and Mental Retardation descriptive brochure, January 1974, p. 9, and *The Executive Budget*, p. 307.

- The facility should have an active and appropriate staff training program that includes induction training for each new employee and continued inservice training for all employees.
- Chemical restraint should not be used excessively.
- The design, construction, and furnishing of resident living units should be appropriate to the program. Furnishings should be comfortable and homelike.
- In addition to adequate resident living services, residents must also be provided with the professional and special programs that they need.
- Educational services should be made available to all residents.
- Sufficient psychological services should be provided to facilitate the optimal development of each resident.
- The facility should provide all of its residents with habilitation and rehabilitation services that will insure the optimal development or restoration of each.⁸²

The 1974 non-accreditation report concludes with the following largely negative "Summary and Conclusions:"

The Mental Retardation Program of the Nevada Mental Health Institute is severely handicapped by physical facilities that are not well suited to a modern mental retardation habilitation program. Furnishings are inadequate and in poor condition. While some isolated attempts at improvement are evidenced in newly remodeled bathrooms and in some nicely decorated dormitories in one of the five wards, the overall physical environment is basically sterile and impoverished. The staffing of the mental retardation unit is extremely sparse. There are from two to four direct-care staff on the wards during the first two shifts, and one direct-care staff member on the wards during the third shift. Some badly-needed professional expertise, such as speech and hearing, is not represented at all on the staff that is available to the unit. Other professions, such as psychology and physical therapy, have less than one full-time staff member providing services to the program. The remainder of the special services, except for medicine and dentistry, do not have enough staff members to provide services to all the residents who need them. The foster grandparent program, with a staff of 32, does provide a variety of services to residents. Working four-hour shifts, five days a week, the program makes a valuable contribution to the mental retardation unit.

Programming decisions are made in one of three ways: direct intervention by medical personnel; contractual, cooperative agreements between ward personnel and special service staff; or team decisions by direct-care staff supervised by nursing personnel under the direction of the clinic administrator. None of these methods, of course, conform to the requirements for interdisciplinary evaluation and programming for each resident.

The staff does demonstrate a determination to improve services for the residents. In spite of only nominal community support and distressing physical conditions, it is encouraging to see this resource. It should be an invaluable asset to the envisioned progress of the program.

Considering the limitations of architecture, furnishings, and personnel resources available to the facility, it is unfortunate that no organized attempt is being made by community or parent organizations to meaningfully support the facility's staff in their attempt to secure additional resources. . . .

Rating by Accreditation Council, February 26, 1974: No accreditation.⁸³

The 1975 non-accreditation report noted certain improvements, but the basic

⁸² J. H. St. Louis, Accreditation Council for Facilities for the Mentally Retarded, Joint Commission on Accreditation of Hospitals, Chicago, Illinois, report attached to a letter to V. LoCicero, Director, NMHI, March 21, 1974.

⁸³ Ibid.

deficiencies in program, level of staffing, and facilities remained. Excerpts from the 12-page list of deficiencies are given below:

- The facility remains unable to provide all the services needed to ensure the optimal development or restoration of each resident, physically, psychologically, socially, and vocationally. Deficiencies exist in the provision of certain aspects of normalized living experiences to all residents, especially residents of Units 3 and 5, and services in speech development, education, psychology, recreation, and physical therapy are insufficient to meet the needs of the residents.
- Due to insufficient staff and the number of residents whose behavior problems are not under control, living unit staff still find it difficult to train residents in activities of daily living and in the development of self-help and social skills, especially in Unit 5.
- Additional food service staff is necessary to adequately supervise the serving of food to the residents, and the dining room should be sufficiently staffed for the direction of self-help eating procedures and to assure that each resident receives an adequate amount of food. Additional education, nursing, physical therapy, psychology, recreation, religious, social services, and speech and hearing staff are needed to provide each resident with the necessary and appropriate evaluation and therapy services.

The 1975 non-accreditation report ends with the following largely negative but hopeful conclusions:

The Mental Retardation Program of the Nevada Mental Health Institute has continued its difficult evolution toward achieving a developmental and training orientation for meeting the needs of its residents. Once the step-child of a large psychiatric program, the Mental Retardation Program has made considerable progress in establishing its own identity. It is hoped that, with the guidance of a new administrator and with financial support from the state, this program will eventually be able to provide the services necessary to meet the needs of all its residents.

Difficulties still remain due to insufficient staff at both the direct-care and professional levels, as well as inadequate living unit design and furnishings. Progress has been made in Unit 4, where residents enjoy a more homelike atmosphere and maintain their own possessions, but Units 3 and 5 still lack the barest semblance of a homelike or normalizing environment.

Staff are enthusiastically undertaking a new interdisciplinary process which should, in time, bring the facility into compliance with the standards regarding the team's membership and function.

The community is becoming more aware of the needs of the residents in the program, and hopefully, will be helpful in persuading state officials to provide adequate funding for better staffing ratios and better living conditions for the residents. . . .

Rating by Accreditation Council, June 11, 1975. No accreditation.⁶⁴

Requesting a survey for accreditation is a voluntary matter, with part of the survey cost borne by the requesting institution. Since the establishment of the Accreditation Council for Facilities for the Mentally Retarded of the JCAH in 1973, 100 facilities have thus far requested surveys, and by the fall of 1975 evaluations had been conducted on 92. Of these, 30 percent received accreditation.⁶⁵

⁶⁴ Ibid.

⁶⁵ In California, for example, the Mental Retardation Program at Camarillo State Hospital and the Comprehensive Developmental Training Center at Napa State Hospital are both accredited as Residential Facilities for the Mentally Retarded by JCAH (mimeographed list of accredited facilities provided by Dr. T. Crosby, JCAH, Chicago, Illinois, dated July 20, 1975).

According to the council chairman, Dr. T. Crosby,** the main purpose of the survey is to provide a method of program evaluation rather than to provide accreditation. The impetus of the survey is to improve services.

The council's standards are established to bring mental retardation services up to an acceptable *minimum level*. Whereas the mental health portion of the NMHI meets most, but not all, of the minimum standards established by the JCAH, the mental retardation section of the Institute falls below acceptable minimum standards.

Since the mental retardation wards are part of the NMHI, accreditation of the whole facility can be lost if a portion of the facility fails to be accredited after four consecutive tries. This could mean the loss of certain federal funds, such as Medicaid.

The Nevada Division of Mental Hygiene and Mental Retardation is aware of the problems with service to mentally retarded people at the Institute; the Associate Administrator for Mental Retardation indicated that his strategy is, "If we can't replace it or improve it, we'll vacate it."⁸⁷ In fact, the census of mentally retarded people at the Institute fell from 140 people in mid-1974 to about 110 in August 1975, and no mentally retarded person from the Las Vegas area has been newly admitted to the Institute in the past two years. However, the associate administrator indicated that there are probably retarded people being kept in the community in Las Vegas who need full-time residential care and training but whose families are waiting for the opening of the new Desert Developmental Center rather than sending them to the Institute.⁸⁸

The principal of the Helen J. Stewart School in Las Vegas, which serves only trainable and more severely mentally retarded youth, claimed with apparent justification that some of NMHI's retarded residents could be effectively served by the Helen J. Stewart School or Variety School in Las Vegas (at \$3500 per year per child), while living with their families or in foster homes. They could do so, that is, if they were from Clark County instead of some other Nevada county that does not have a comparable excellent special education program for more severely handicapped children.⁸⁹

DESERT DEVELOPMENTAL CENTER

The Desert Developmental Center, a \$2,495,000 Division of Mental Hygiene and Mental Retardation facility, is to be constructed in Las Vegas. It will provide a broad range of services for mentally retarded southern Nevadans, from fully dependent residential care for the most profoundly retarded nonambulatory people, to training for less severely retarded people, to help them progress to the least restrictive environment in which they can become capable of living. Outpatient services, training of families, counseling of families with retarded members, and follow-up services for former residents are also planned.⁹⁰

⁸⁶ Telephone interview conducted September 1975.

⁸⁷ Interview with J. Middleton, August 5, 1975.

⁸⁸ Ibid.

⁸⁹ Interview with Dr. Robert Foster, Helen J. Stewart School, Las Vegas, Nevada, October 25, 1974.

⁹⁰ "Desert Developmental Center," Nevada Division of Mental Hygiene and Mental Retardation, 1975.

The new center will consist of five distinct facilities: a service facility for outreach services and support staff; a residence for about 8 people, located in the community and used for training the residents for transition to a less dependent living situation; two residences for longer-term care and services to about 28 multihandicapped severely and profoundly retarded people; a residence for about 8 retarded people to be used to provide intensive training for those with behavior problems; and a residence for about 12 retarded adults, to be used for training the adults to move to more independent living situations in the community. The facilities would provide residential services to about 56 retarded people, and have a proposed staff of 61, who would not only serve those 56 but also provide some services each year to approximately 150 nonresidents (for a total of 200). In early 1976, a staff of nine were beginning to implement the community-based component of the center.

The stated intention of the Division of Mental Hygiene and Mental Retardation is to remove all 51 mentally retarded southern Nevadans from the NMHI residential program in Sparks, to place them in another residential program in Las Vegas, and (to the extent the capacity of the Desert Developmental Center allows) to prevent sending any retarded southern Nevadans to the Institute in the future. (In fact, as we indicated earlier, none have been sent to the Institute from Las Vegas for the last two years.) Note that the residents to be moved from the old Institute to the new center will still be in a 24-hour residential care setting (albeit a nicer one nearer their families). Services necessary to train these people to the point where they can live in a less dependent program could be offered either at the Institute or at the center. Our point is that the goal of deinstitutionalization is furthered more by the improved services than by the new facility. The improved services could also be provided at the Institute if it had sufficient staff, which the legislature has not approved for the Institute but apparently will approve for the new Desert Developmental Center since it has approved the center's construction. This point about services as distinct from facilities leads us to another future Division proposal.

The division also plans to request funding from the legislature in its next session in 1977 for another "Desert Developmental Center" for northern Nevada.⁹¹ If the legislature approves that request, the NMHI's mental retardation section will be vacant. Consequently, rather than attempt to improve services at an old and somewhat unsuitable physical facility, the division apparently plans to abandon mental retardation services at the Institute.

EAGLE VALLEY CHILDREN'S HOME

The Eagle Valley Children's Home in Carson City is a private nonprofit residential facility, primarily for severely and profoundly mentally retarded children.⁹² It has a capacity of 25 residents, but since September 1974 has usually served only 10. It does not advertise for additional residents.

The home was started for a trainable mentally retarded son of the founders. The rest of the children are severely and profoundly retarded, aged 4 through 8 years. Most are multiply handicapped. Charges are \$300 per month per person, and 5 of

⁹¹ Letter from J. Middleton, Nevada Division of Mental Hygiene and Mental Retardation, to J. Kakalik, The Rand Corporation, January 21, 1975.

⁹² Interview with M. Tomlinson, Eagle Valley Children's Home, Carson City, Nevada, September 20, 1974.

the 10 clients receive their payments through welfare. Medicaid pays for health care for those on welfare, above the \$300 per month; privately financed residents pay extra for medical services. Three of the residents attend the Ormsby Association for Retarded Citizens' School for physical therapy and training. The remainder are provided residential and nursing services, plus daily recreation and physical exercise. While separate legal entities, in 1976 Eagle Valley is under the administration of the director of the Ormsby Association for Retarded Citizens.

The Eagle Valley facility is licensed as a child care home. The physical plant is homelike in atmosphere, with well-decorated, pleasant, and well-kept rooms. Aside from the NMHI, it is the only residential facility for severely and profoundly retarded children in Nevada.

The staff consists of three persons on the day shift and two persons each on the evening and night shifts. The nurse-director has 15 years' experience as a registered nurse and 5 years' experience working with mentally retarded people in Illinois. All staff have had a first aid training course and are informally trained by the nurse in charge as necessary.

NORTHERN AND SOUTHERN NEVADA MENTAL RETARDATION CENTERS

The Nevada Division of Mental Hygiene and Mental Retardation operates two mental retardation centers for mentally retarded adolescents and younger adults who are not yet functioning at a level that would enable community living.²² Both provide residential care and training services. Northern Nevada is served by a 26-bed center in Sparks, southern Nevada by a 28-bed center in Las Vegas.

The centers offer short-term service only (on the order of weeks or months) that will prepare the resident for eventual return to his or her family or other community living (see the discussion on residential living in Chap. 13). People needing long-term residential care are served at the NMHI in Sparks, and in the future will be served at the Desert Developmental Center to be constructed in Las Vegas. Most new residents at the centers already have basic self-help skills; the centers' programs work to increase their social, educational, and vocational skills. Some small amount of consultation and training is also provided to a minority of the resident's families, as is short-term respite care (of a few days' duration) for retarded persons whose parents, foster parents, or developmental home supervisors need temporary assistance or are temporarily unable to fulfill their normal responsibilities.

Applicants for residential placement, even court commitments, are considered on a space-available basis using very restrictive criteria. They are considered for admission if: "they are mentally retarded in accordance with the AAMD definition of mental retardation [see Chap. 3]"; "no other resources in the community are available, or can be reasonably developed, that can meet the physical, intellectual, and emotional needs of the applicant"; "it can be shown that the applicant can be expected to benefit from the programs available, or that programs can be reasonably

²² Interviews with E. Pillard, Clinic Administrator, Northern Nevada Mental Retardation Center, Sparks, Nevada, August 21, 1974, and F. Cline, Clinic Administrator, Southern Nevada Mental Retardation Center, Las Vegas, Nevada, July 16, 1974, and a letter from J. Middleton, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, February 10, 1976.

modified to meet the applicant's needs"; and "wherever possible, there is a commitment of reasonable involvement by parents or other persons designated as responsible guardians."⁹⁴ No person is admitted to a residential program if "there is clear, current evidence of an emotional, physical, or psychotic condition that would preclude benefit from the program at the time of evaluation by the Division."⁹⁵ When immediate admission is not possible due to lack of space, the division attempts to provide consultation and training for the applicant and his or her family.

Two Interdisciplinary Committees, one for northern and one for southern Nevada, make decisions regarding admission of retarded people to the NMHI and to the mental retardation centers. The committees "serve as the primary point of contact for families, guardians, and other individuals and groups concerned with the disposition and progress of the case throughout the entire period during which any Division services are provided. . . ."⁹⁶ They review and recommend a course of services for new applicants for services in division programs and for existing clients on an ad hoc and nonperiodic basis as they may require major changes in services. The committees provide some "direction" of retarded people to the most appropriate services within and outside the division's programs (see Chap. 4 for a discussion of the direction service). They do not serve all mentally retarded people, however, but only applicants and clients of the division's residential programs at the NMHI, the two mental retardation centers, and the program of sheltered residential living in developmental homes. Community training center clients, for example, are served with division funds but in practice do not receive the benefit of attention from the interdisciplinary committees.

Each of the two committees is chaired by the clinic administrator of the corresponding regional mental retardation center. Membership consists of "a member of the [Division of Mental Hygiene and Mental Retardation's] Mental Retardation Services staff, a regional social worker, a regional psychologist, a regional educational specialist, a regional vocational specialist, a regional medical consultant, and the Clinic Administrator of the Nevada Mental Health Institute—Mental Retardation Units, or his designee."⁹⁷ Decisions require the concurrence of at least a two-thirds majority.

Residential care and activities of daily living training are provided directly by the Northern and Southern Nevada Mental Retardation Center staff members. Training techniques are diverse but are primarily "behavior modification" oriented, using positive reinforcement for desired behavior. The centers purchase medical and dental services (including annual examinations) and sometimes speech therapy from local professionals. Special educational services are provided to residents of school age by the county school district. These are supplemented by the work of one or two teachers or teaching aides at each of the MR Centers for residents under age 21 (the federal P.L. 89-313 funds used for the teaching aides cannot be used for residents over age 21). At the time of our interviews, the centers did not provide

⁹⁴ "Admissions Policy Statement," Administrative Memorandum No. 18, revised June 13, 1974, from J. Middleton, Associate Administrator for Mental Retardation, Nevada Division of Mental Hygiene and Mental Retardation, to all staff members, Reno, Nevada, June 21, 1974.

⁹⁵ Ibid.

⁹⁶ "Interdisciplinary Committee Structures and Responsibilities," Administrative Memorandum No. 16, revised June 13, 1974, from J. Middleton, Associate Administrator for Mental Retardation, Nevada Division of Mental Hygiene and Mental Retardation, to all staff members, Reno, Nevada, June 20, 1974.

⁹⁷ Ibid.

mental health services. Residents' families are encouraged to visit, and frequent trips are made with residents into the community for social, recreational, and other purposes to increase contact with nonretarded persons.

The centers work on reducing each resident's skill deficits and sometimes set up contracts with his or her parents whereby, if the child achieves certain skills, the parents will take the child back into the family home. Children without family homes to rejoin can be discharged to private developmental homes in the community for sheltered or semi-independent living (see Chap. 13).

The physical plants of the two centers are nearly identical. They are modern intermediate care facilities, pleasantly furnished, with individual bedrooms off a central area containing living, dining, and kitchen facilities. To the extent of their abilities, residents are taught to care for their own personal needs and rooms, as well as other housekeeping skills such as cooking. Certain physical differences between the centers also were evident. One center had significantly more wall decorations and residents' personal possessions than the other rather sterile one; and one had a padlock on the refrigerator.

The full-time professional staff at the northern center consists of the clinic administrator (a social worker), two other social workers, a nurse, and one teacher. They are assisted by a full-time-equivalent staff of 19, including 14½ full-time-equivalent "technicians," 2 secretaries, 2 teaching aides (paid by a P.L. 89-313 federal grant), a custodian, a groundskeeper, and a cook. The staff has no nurse and no psychologist. A private psychiatrist meets with the northern center staff about twice a month to help with evaluation, prescribe drugs, and counsel the staff on how to work with residents. About one-fifth of the northern center's residents and about one-third of the southern center's residents are on psychotropic drugs.

The Southern Nevada Mental Retardation Center staff of 23 consists of a clinic administrator, who is a nurse with extensive experience in working with retarded people in a residential care and treatment setting, 1½ full-time-equivalent social workers, a teacher's aide, a prevocational skills training and counseling person, 14½ full-time equivalent technicians, a custodian, a cook, a clerk, a secretary, a consultant psychologist who does preadmission testing, and a consultant physician. No other psychologist's or psychiatrist's services are provided. According to the administrator, the few psychotic mentally retarded residents are treated with "behavior modification" techniques.

The southern center administrator occasionally discusses residents with the staff of the Children's Behavioral Services program, but she said the two programs were effectively split as far as day-to-day operations were concerned. Also, the CBS staff uses behavior modification techniques almost exclusively, while some retarded residents at the center primarily need other types of psychological services for mental health problems.

Because reportedly no other program in the state will accept them, chronically schizophrenic young people who have become functionally retarded are sometimes served at the mental retardation centers, even though the program is not fully appropriate for them.** In the recent past there has been no residential treatment program for emotionally disturbed children in Nevada; the neuropsychiatric section for the NMHI does not usually serve children. In the future, however, some cases of functional retardation may be prevented as the total lack of residential treatment

** Interview with E. Pillard.

services in Nevada for emotionally disturbed children is alleviated to some extent by the new Las Vegas Mental Health Center residential program, and the to-be-constructed CBS residential treatment facilities for emotionally disturbed children.

Training for new staff members of the northern center consists of orientation from the clinic administrator and the workshift supervisor, plus a first-aid course; the rest of the training is "on-the-job." The southern center also lacks a formal in-depth preservice or in-service training program, and the technicians are untrained at the time they are hired; rather, the administrator and the two social workers provide informal on-the-job training.

In August 1974, the northern center had 26 residents, one day-only client, about 10 people placed in their own parents' homes who benefited from occasional respite care and counseling of the parents, 11 people in developmental homes supervised by MR Center personnel, and 10 people on a preadmission screening list (officially there is no waiting list, but people can be kept in preadmission screening for an extended time). The clinic administrator of the northern center indicated a clear need for expanded service capacity of the type provided by the center in northern Nevada.

The southern center typically has 22 to 24 residents, but had three more children in July 1974 who had been admitted for the summer only; the three return home to their families during the months when school is in session. Most residents were moderately retarded, a few were severely retarded, and none were mildly retarded. About half the residents (of both centers) were formerly at the NMHI and are now in a transitional phase as attempts are made to enable them to return to community living. In the summer of 1974 the residents were aged 5 to 30 at the southern center. The center also had five younger clients who were served primarily on a consultant basis in their own homes. One of the residents at the southern center is both deaf and mentally retarded; according to the administrator, no one at the center can communicate well with this child. The southern center staff also supervised 14 persons living in developmental homes in the community in July 1974.

In calendar year 1973 there were 12 residents released from the northern center and 9 residents released from the southern center. In that same year, each center made 20 to 30 respite-care admissions, and each served 6 or less persons on a day-care basis.

Rand staff members talked to half a dozen families of residents. The families were reasonably satisfied with the services received, with two exceptions: the majority cited delays in gaining admission to the center; and they expressed very strong feelings about the need for more counseling of the families regarding their feelings toward their mentally retarded children, counseling about life with the children, and counseling on how to help their children develop. We note that not only are psychological counseling needs of families not being met, but also several of the retarded residents are not receiving needed psychological or psychiatric services. The staffs of the two centers do not have the professional background needed to meet the mental health needs of the mentally retarded residents and their families, and the staffs of mental health service programs in Nevada almost never serve mentally retarded people or their families (even in Las Vegas, where the driveway separating the Mental Retardation Center and the Mental Health Center might as well be several miles wide, so seldom is it crossed in practice). For example, when asked about the Las Vegas Mental Health Center's services to mentally retarded clients,

the administrator's instant response was, "What mentally retarded clients?" Nor do mental health centers ordinarily serve mildly retarded people who are functioning above the level of those served by the mental retardation centers. In practice, consequently, any counseling they receive comes from special education personnel, and only then if the clients are of school age. Nevada's lack of adequate mental health services to mentally retarded people is a major deficiency in the current service system.

Since the mental retardation centers are intended to help residents develop the skills they need to move into less restrictive community living settings, we expected to encounter good vocationally related services. However, of the eight northern center residents over age 18 in August 1974, only three were receiving any state Vocational Training or Vocational Rehabilitation program services (see Chap. 11 for a description of those programs); those three were developing skills needed for sheltered employment. The administrator of the southern center reported that none of her residents were receiving any *significant* amount of services from the Vocational Rehabilitation program.

In FY 1975 the salary and fringe benefit costs of the northern and southern MR centers were about \$221,000 and \$239,000, respectively. Travel for staff of the two centers plus members of the division headquarters mental retardation staff was just over \$10,000. Other operating expenses totaled about \$175,000 (including \$58,000 for food, and \$27,000 for medical, dental, and other contractual expenses).^{**} Thus the total annual operating cost of the two centers combined is about \$645,000. This total includes some small amount of division headquarters travel and other operating expenses that does not go directly for the MR centers, but this is offset to some degree by services the mental retardation centers' staff perform on the interdisciplinary committees that are not exclusively related to the center's operations. With an average total resident population at the two centers of about 50, the annual operating expenses per resident were about \$12,900, but this includes the cost of services provided to nonresidents, such as those receiving day care and respite care, and the cost of supervising the developmental homes. Thus, the operating cost *specific* to the full-time residents is less than \$12,900 a year, probably around \$10,000.

Since FY 1975, the northern and southern MR centers have become certified Intermediate Care Facilities (ICF), and about 70 percent of the clients are eligible for \$25 monthly S.S.I. benefits (see Chap. 14 for a description of the S.S.I. program), Medicaid benefits, as well as other ICF reimbursements.

Summer camping experience for some mental retardation center residents and many other mentally retarded Nevadans was provided in 1974 with support from a \$35,000 grant by the Max C. Fleischmann Foundation.¹⁰⁰ About 150 mentally retarded children and young adults spent a week (about 50 at a time over a three-week period) at Camp Lodestar in California. Many were from the residential programs at the NMHI and the Northern and Southern Nevada Mental Retardation Centers. Many others learned of the program from staff members of the various community training centers, special education program personnel, and newspaper

^{**} *The Executive Budget.*

¹⁰⁰ H. Nuwer, "A Camp Program for the Mentally Retarded: Evaluation Report," submitted to the Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, August 6, 1974 (mimeograph). See also M. Rockenbeck, "A Camp Program for the Mentally Retarded: Evaluation Report," submitted to the Nevada Division of Mental Hygiene and Mental Retardation, Reno, September 10, 1973 (mimeograph).

articles. The number of staff members and nonretarded campers was about the same as the number of retarded campers. A full week of staff training preceded the encampment. To help defray expenses, a small charge of up to \$40 per participant was made to parents and guardians. External evaluations concluded that the program was a rewarding experience for nearly all participants. However, we question the necessity of flying participants from the Las Vegas area to the Reno area and then sending them 160 miles by ground transportation to California, when a similar camping experience (perhaps for smaller groups over a longer time) probably could be provided at existing campgrounds nearer home for less cost and travel time.

The Community Awareness program staff is affiliated with the mental retardation centers and other Nevada facilities. With an FY 1975 budget of \$143,000, this program is federally funded under P.L. 89-313, which provides for financial assistance to state-operated and state-supported special education programs for handicapped youth. Nevada's program is serving about 140 mentally retarded youth aged 3 to 21 years in Reno and Las Vegas who are residents of the NMHI and the Northern and Southern Nevada Mental Retardation Centers.¹⁰¹ The program also assists about two dozen emotionally disturbed children and youth in the day program operated by the Reno Mental Health Center. Both classroom instruction and field trips into the community are used to provide special education and developmental training. In FY 1975 the program was staffed with one special education consultant, four teachers (two at the Reno Mental Health Center and one at each of the mental retardation centers), one teacher's aide, one speech therapist (at the Institute), and 2.5 public service interns. In February 1976, this program had a staff of 13 and an annual budget level of \$148,000.¹⁰²

The Division of Mental Hygiene and Mental Retardation operates another small program in the Las Vegas area to train parents and families to deal with the problems of mental retardation in the home setting for people who might otherwise need residential care and training at the NMHI or the Southern Nevada Retardation Center. The program is called "Community Relevant Habilitation for the Developmentally Disabled." It is funded by a small Federal Developmental Disabilities grant (about \$30,000 in FY 1975), and operates out of the Southern Nevada Mental Retardation Center. The staff members also perform a "direction" service function (see Chap. 4) by attempting to coordinate a full range of services to individuals. The objectives of this program are admirable, and it is unfortunate that it does not include areas of Nevada outside of Las Vegas; however, given the small staff size of three full-time-equivalents, we doubt that the need for such service is being met even in Las Vegas.

The Mental Retardation Staff at the headquarters of the Division of Mental Hygiene and Mental Retardation numbered 12 in FY 1975, for an annual cost in salaries and fringe benefits of about \$166,000.¹⁰³ The staff performs planning functions for the growing Nevada mental retardation service system. It also provides some administrative and consultative services not only for the Northern and Southern Nevada Mental Retardation Centers, but also for the to-be-constructed Desert

¹⁰¹ *The Executive Budget.*

¹⁰² Title I—P.L. 89-313 Proposed Grant, FY 1974-75, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, April 1974, and a letter from J. Middleton, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, to J. S. Kakalik, The Rand Corporation, Santa Monica, California, February 10, 1976.

¹⁰³ *The Executive Budget.*

Developmental Center, and for the Community Training Center, resident placement in Developmental Homes, and Community Awareness (P.L. 89-313 special education and training) programs. However, each of those programs also has its own separate administrative staff.

In addition to the intermediate type of residential care and developmental training services provided at the Northern and Southern Nevada Mental Retardation Centers, Nevada has several other intermediate care facilities that do not have a service or developmental training program designed specifically for mentally retarded people, but that do accept them for intermediate levels of residential care (see Chap. 13).¹⁰⁴ The facilities include Ruby Mountain Manor in Elko, the Fallon Convalescent Center, Golden Age Gardens in Reno, and, in the Las Vegas area, the Vegas Valley Convalescent Hospital, Gaye Haven, Glen Halla, and the Torrey Pines Care Center. Note that only four Nevada counties have such facilities. The Nevada Welfare Division will pay for care of some individuals in these facilities.¹⁰⁵

NEEDED IMPROVEMENTS: RESIDENTIAL MENTAL RETARDATION SERVICES

We again emphasize that residential mental retardation services are improving in Nevada and that current staff people by and large are dedicated and hardworking. Adequacy of services is still a far-distant goal, however.

The greatest inadequacy in the present system is in the NMHI Mental Retardation program. The program twice has failed to receive JCAH accreditation, for the reasons discussed earlier, mostly stemming from a staff that is deficient in numbers, training, and mix of professional skills. *We strongly recommend that the NMHI mental retardation program be improved to meet JCAH accreditation standards.* The facility improvements at NMHI and the new Desert Developmental Center approved by the 1975 Nevada Legislature will help upgrade the NMHI program by improving physical living conditions at NMHI and by cutting the NMHI resident population approximately in half. Since 1974, the NMHI's mental retardation program has made internal changes that have changed the quality and quantity of services provided for the current resident population. These changes are seen by NMHI as only beginning steps that are necessary to ultimately bring the residential program into compliance with accreditation standards. An attachment to a letter from NMHI Director T. Piepmeyer to Rand on February 27, 1976, stated, "These program changes are pitifully inadequate unless additional resources outside the existing program are obtained in the form of staff, training and proper mix of professional skills." The two primary internal changes using existing staff are a new day training center and an interdisciplinary committee to evaluate and plan services for each individual resident.

Given the extensive service program planned and needed for the population of more severely mentally retarded southern Nevadans, we recommend that the proposed Desert Developmental Center staff be approved by the legislature in 1977. We further recommend that the mental retardation staff of the Institute not be cut

¹⁰⁴ *Rehabilitation Facility Plan, 1975-80*, Rehabilitation Division, Nevada Department of Human Resources, Carson City, Nevada, January 1, 1975.

¹⁰⁵ *Ibid.*

when about half of the Institute's residents are moved to the new center, so that the Institute will then be able to provide more nearly adequate services to the retarded residents remaining there. Interdisciplinary NMHI teams have been functioning since March 1975; 86 of the 108 persons now in NMHI's mental retardation program have been reviewed, individual client needs identified, and a corresponding treatment/training plan has been developed for each of them. About 50 percent of the activities identified in these plans have been deferred due to inadequate staff, according to an NMHI administrator.

We agree that the concept of a new northern Nevada equivalent of the Desert Developmental Center is a good idea, but we question the priorities and timing. The Institute already exists, after all, and the new Desert Developmental Center in Las Vegas will provide improved services. On the other hand, facilities are either totally absent or too small for services to some other groups of mentally handicapped people, or for other types of services for mentally retarded people. It seems to us that first priority on new facility construction should go where none exists at all, rather than where a facility exists that could be better. *Hence, we recommend that approval for the construction of the northern Nevada equivalent of the Desert Developmental Center facility be deferred until other higher-priority expenditures have been made.* (See Chap. 2 for a discussion of priorities.) We do not mean to imply that the Institute's mental retardation facilities are good enough or that we condone the inferior services its residents now receive. Rather, we believe the Institute's services can be sufficiently improved within the existing facility, so that construction of a new facility can be deferred while other higher-priority needs are met. *We recommend that the NMHI and the Northern Nevada Mental Retardation Center provide services for northern Nevadans corresponding to those that the new Las Vegas Desert Developmental Center will provide.*

We recommend that control of the mental retardation program be separated from that of the mental health program at the Nevada Mental Health Institute, and be given to the Associate Administrator for Mental Retardation of the Nevada Division of Mental Hygiene and Mental Retardation. This is in recognition of the separate spheres of activity that now exist at NMHI and compete for resources. We do not envision physically removing all mentally retarded people from NMHI at the present time, although that might be done in the future. Rather, the intent of this recommendation is to consolidate the administration of mental retardation programs. At present, the largest residential program for mentally retarded people in the state is not the responsibility of or within the direct sphere of control of the DMHMR Associate Administrator for Mental Retardation; that seems to be an unnecessary and undesirable disaggregation of responsibility. Auxiliary services and facilities for mentally retarded residents at NMHI, such as medical care and recreational facilities, could be obtained from the non-mental-retardation portion of NMHI as they are now; NMHI's bookkeeping system is such that it would not be overly difficult to arrange for the appropriate interprogram transfer of funds.

The current training for state-employed mental health technicians at the mental retardation centers and the NMHI is inadequate, and in practice even falls short of the officially stated job requirements. *Hence we recommend that the technician staff be given formal training in the provision of developmental services to mentally retarded people.*

Virtually no mental health services (other than drugs) are provided to mentally

retarded people living at the NMHI, the two mental retardation centers, or anywhere else in the entire state. Although not all mentally retarded people and their families need mental health services, some clearly do. Hence *we recommend that provision be made for mental health services to those mentally retarded people and their families who need them.* A difficulty that must be overcome, however, is that the mental health service system in practice seldom serves retarded people and is separate from the mental retardation system, which itself typically does not hire mental health professionals.

Rather than have both the NMHI and the mental retardation centers developing and supervising community home placements of mentally retarded people, *we recommend that all community developmental home programs be under the auspices of the mental retardation centers.* With the NMHI program for mentally retarded people as deficient as it is, it makes little sense to have the Institute take on different responsibilities that greatly overlap those of the mental retardation centers.

At the private Eagle Valley Children's Home, primarily for severely and profoundly retarded youth, only three of the ten residents were receiving special education and training in September 1974. *We recommend that nearly all Eagle Valley Children's Home residents be provided needed special education and training by the Carson City School District, with an extra special education unit (\$16,000) provided by the Nevada Department of Education for that purpose, since not all the residents originally come from Carson City.*

We recommend that mentally retarded prisoners be identified and that a special program of services be established for them. At present, the Nevada State Prison system has no idea how many prisoners are mentally retarded, and provides no special services for them, other than allowing them to participate in basic adult and remedial education classes. To some unknown degree, special services would certainly improve the quality of their lives and their level of functioning following release from prison, and would probably reduce the incidence of their commission of crimes.

On the matter of geographic availability of services, we again note the persistent tendency in Nevada to plan and approve facilities of the same size in Reno and Las Vegas (e.g., the MR Centers and the Desert Developmental Centers, and to build no residential mental health and mental retardation treatment facilities in rural Nevada. We believe those practices are largely justifiable, as long as the service system is so administered that rural Nevadans have access to the Reno and Las Vegas facilities. The rural population is sparse, only a few people need residential services in any single rural locale, and it is both costly and difficult to maintain professional staffing and specialized services in small rural facilities.

Given that the Reno and rural populations are about the same size, and that the Las Vegas population is about equal to the Reno and rural populations combined, it is equitable to build equal-size facilities in the north and south only if each area gets its fair share of the service. In practice this means that about half of the Reno facility should be devoted to serving rural Nevadans, most of whom live in northern Nevada. Less service-intensive and longer-term residential living (e.g., developmental homes) could still be provided in rural Nevada (see Chap. 13).

We recommend that an improved information system be established for monitoring mental retardation program operations, including the effectiveness of services. A discussion of the existing information system and desirable improvements in it were

presented in the "Individual Client Data Base" subsection of our discussion above on the "Nevada Mental Health Institute: Mental Retardation Program."

Finally, we reiterate the need for direction and coordination of services, and refer the reader to Chap. 4 for our *recommendations for the creation of Regional Direction Centers*.

Chapter 11

VOCATIONAL SERVICES

OVERVIEW OF CURRENT VOCATIONAL SERVICES

This chapter discusses several major vocational service programs for mentally handicapped Nevadans, estimates vocational service needs, presents recommendations for improvement, and makes projections to 1985.

We estimate that at least 680 Nevadans with mental health problems, 660 with mental retardation, and 410 with alcohol or drug abuse problems had a need for vocational services in 1975. These are conservative estimates that do not include people who need only job placement assistance (a much larger number of people fall into this category), and do not include youth who are not in their last two years of school. Methods of estimation and sources of these and all other data in this overview are presented later in this chapter.

The five major vocational service programs serving mentally handicapped Nevadans, as shown in Fig. 11.1, are found in three different state departments and in the private sector: the Vocational Rehabilitation (VR) program in the Department of Human Resources Division of Rehabilitation; the Community Training Centers (CTC) program, which partially funds private community vocational centers, and the Vocational Training (VT) program, both in the Nevada Department of Human Resources Division of Mental Hygiene and Mental Retardation; the county special vocational education (VE) programs, partially funded through the Nevada

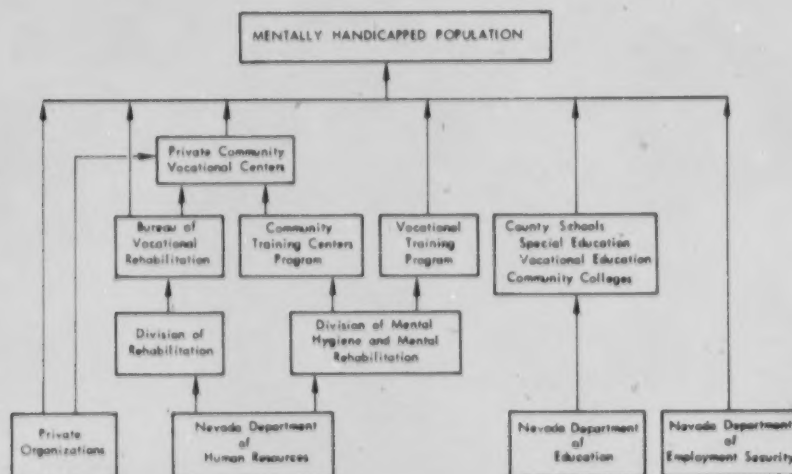


Fig. 11.1—Organization of major vocational service programs for mentally handicapped Nevadans

Department of Education; the Department of Employment Security (ES) programs, including those funded by the Comprehensive Employment and Training Act; and the private community vocational centers (CVC), funded partially by the Community Training Centers and Vocational Rehabilitation programs.

Table 11.1 gives an overview for each program of the number of mentally handicapped people served, staff, and expenditures in FY 1974 by major type of mental handicap. About 1617 people with mental handicaps received vocational services at an expenditure of about \$2.7 million, or about \$1710 per capita. The 296 clients listed under "other mental" in Table 11.1 were primarily those with disabilities the VR program calls "character, personality, or behavior disorders" (i.e., they do not fall into the other VR program categories as psychotic, neurotic, retarded, alcoholic, or drug abusing persons).

Table 11.2 shows the number of mentally handicapped people provided with vocational services (exclusive of those served by the Department of Employment Security) in the three major areas of the state. In terms of people served per thousand population, there is no major difference between the Las Vegas area, the Reno area, and the combined remaining area of the state. However, as will be discussed later, there are major differences within individual programs in service to the three geographic areas for certain types of mental handicaps.

The largest vocational service program is vocational rehabilitation, which in FY 1974 completed provision of a wide variety of services to 161 people with mental

Table 11.1

SUMMARY OF VOCATIONAL SERVICES TO MENTALLY HANDICAPPED NEVADANS, FY 1974

Item	Vocational Rehabilitation	Community Vocational Centers	Vocational Training Program	Special Vocational Education	Employment Security	All Programs Combined
Estimated number served						
Mental health	161	0	0	0	NA	> 161
Mental retardation	81	183	19	400	NA	> 635
Alcohol and drug abuse	140	0	0	0	NA	140
Other mental	296	0	0	0	NA	296
Total	678	183	19	400	337	1,617
Estimated staff (full-time equivalent)						
Mental health	9	0	0	0	1	10
Mental retardation	2	71	4	12	1	90
Alcohol and drug abuse	5	0	0	0	NA	5
Other mental	18	0	0	0	NA	18
Total	34	71	4	12	1	123
Estimated expenditures						
Mental health	\$ 271,000	0	0	0	NA	\$ > 271,000
Mental retardation	548,000 ^a	\$919,000	\$36,000	\$204,000	NA	> 1,707,000
Alcohol and drug abuse	151,000	0	0	0	NA	151,000
Other mental	596,000	0	0	0	NA	596,000
Total	\$1,566,000	\$919,000	\$36,000	\$204,000	\$32,000	\$ 2,757,000

SOURCES: See text of this chapter for sources of data.

NOTES: In some cases, the numbers served for each program do not add to the total served by all programs combined, since a person can be counted as served by more than one program. NA = not available.

^aIncludes \$483,000 in one-time grants for local program and facility improvement projects.

Table 11.2
 VOCATIONAL SERVICES TO MENTALLY HANDICAPPED NEVADANS BY GEOGRAPHIC
 AREA, 1974

Geographic Area	Program and Estimated Number Served					All Programs Combined
	Vocational Rehabilitation	Community Vocational Centers	Vocational Training Program	Special Vocational Education	Employment Security	
Clark County (Las Vegas area, except Mental Health Institute)						
Mental health	56	0	0	0	NA	56
Mental retardation	41	110	0	240	NA	391
Alcohol and drug abuse	76	0	0	0	NA	76
Other mental	90	0	0	0	NA	90
Total	263	110	0	240	NA	613
Total per 1000 population	0.8	0.3	0.0	0.8	NA	1.9
Washoe County (Reno area, except Mental Health Institute)						
Mental health	27	0	0	0	NA	27
Mental retardation	16	40	19	70	NA	145
Alcohol and drug abuse	4	0	0	0	NA	4
Other mental	93	0	0	0	NA	93
Total	137	40	19	70	NA	269
Total per 1000 population	1.0	0.3	0.1	0.5	NA	1.9
All other counties combined (except Mental Health Institute)						
Mental health	16	0	0	0	NA	16
Mental retardation	7	33	0	90	NA	130
Alcohol and drug abuse	14	0	0	0	NA	14
Other mental	87	0	0	0	NA	87
Total	124	33	0	90	NA	247
Total per 1000 population	1.2	0.3	0.0	0.8	NA	2.3

SOURCES: See text of this chapter for sources of data.

NOTES: In some cases, the numbers served for each program do not add to the total served by all programs combined, since a person can be counted as served by more than one program. NA = not available.

health problems, 81 people with mental retardation, 140 people with alcohol or drug abuse problems, and 296 people with some other mental disability. These services included diagnosis, evaluation, vocational counseling, medical and psychological restorative service, vocational training and job placement, income maintenance while participating in the program, and other services such as occupational tools and equipment, and transportation. In relation to the annual need based on adults plus youth leaving school each year, the VR program currently appears to be serving about a third of those people in need who have mental health problems or problems of alcohol or drug abuse, and about a sixth of those in need with mental retardation. Since we completed our analysis, FY 1975 data have been compiled by the Bureau of Vocational Rehabilitation. It will be interesting to see the Bureau's quantitative analysis of these data so that the degree to which priorities have changed can be discerned.

Nevada State VR personnel directly provide certain services such as work evaluation, counseling, and placement, and purchase others from public and private vendors, such as medical and psychological services, and work evaluation and train-

ing. For example, the Washoe Association for Retarded Citizens and the Opportunity Village in Las Vegas provide vocational service to mentally retarded people under contract with the VR program. The role of the Federal Government is also major; it funds 79 percent of the VR program in Nevada and specifies broad guidelines for service provision.

The VR program operates from eleven offices throughout the state to help handicapped persons obtain gainful employment, which may include family work, sheltered employment, or homebound work, as well as competitive employment. Mentally handicapped clients represented 47 percent of the FY 1974 case closures, and 45 percent of the reportedly mentally handicapped persons referred were accepted for service. The nearly \$1.6 million expended in FY 1974 for mentally handicapped people included a one-time expenditure of about \$0.5 million for facility and program improvement for mentally retarded clients and resulted in the successful vocational rehabilitation of 49 percent of all those mentally disabled people served, attesting to the desirable outcomes of the program. The VR program basically defines success as a favorable prognosis after 30 days of gainful employment.

We are not fully satisfied with the VR program definitions in the mental health area. For example, they list three basic types of disorders: psychotic (no further definition is given); psychoneurotic (no further definition is given); and "other mental disorders" (broken down to "alcoholism," "drug addiction," and "other character, personality, and behavior disorders" but not further defined). The distinction is not at all clear between "psychoneurotic" and "other character, personality, and behavior disorders." The definition of classifications of VR clients, in practical terms, is largely up to the individual diagnostician and can be expected to vary considerably.

Some light is shed on the "character, personality, and behavior disorder" category when one understands that the two largest sources of referrals of people in the category are justice and welfare agencies, and that VR rules for classification of a person as psychotic or neurotic require a more highly educated diagnostician. However, with the above caveats, we now proceed to use the VR classification scheme since data are not available to use any other classification for this program.

The VR program heavily emphasizes people who have an "other mental" disorder of character, personality, or behavior and who are thus not classified by VR as psychotic, neurotic, retarded, alcoholic, or addicted to drugs. Of those accepted for service, 39 percent have an "other mental" disability and half of the FY 1974 closed-case expenditures went to that group alone. In comparison, only 12 percent of those mentally disabled persons accepted were retarded. Of the more prevalent types of mental disabilities, the two categories with the highest average expenditures per client are the psychoneurotic and the nebulous "other mental" categories, although people in those two categories are certainly not the most severely handicapped or the hardest to train and place in jobs. Contrary to what might be expected and desirable, the average expenditures per client accepted for service decrease in some cases as the severity of the mental handicap increases, e.g., from \$742 per mildly retarded client to \$468 per moderately retarded client, and from \$1654 per neurotic client to \$735 per psychotic client.

The VR program has recently grown very rapidly, leveling off in the most recent year for which data were available for our analysis (FY 1974), and service to mentally disabled people has kept pace with the overall program growth. The VR program emphasis on mentally disabled people is heaviest by far on those it classifies

as having personality, character, and behavior disorders, but the relative emphasis is shifting somewhat toward alcohol and drug abusers and mentally retarded people. Since FY 1974, the Administrator of the Nevada Division of Rehabilitation indicates a shift in priorities toward more severely handicapped people, in line with Federally-mandated priorities (see the *Federal Register*, December 5, 1974). The Division's analysis of FY 1975 and early FY 1976 data, when made available to the public, will allow assessment of the quantitative degree to which a change in priorities has taken place.

Looking at the number of mentally disabled persons rehabilitated by geographic area indicates that the figure for rehabilitants per capita is about the same in each of the three major areas of Nevada. However, in certain counties in the geographic area outside Clark County (Las Vegas) and Washoe County (Reno), mentally disabled people were markedly underserved in FY 1974 relative to the rest of the state. For example, in Esmeralda, Eureka, Nye, and Storey Counties combined, not even one mentally disabled person was vocationally rehabilitated and only two were served.

Certain VR offices also tend to "specialize" in certain disabilities. For example, rehabilitation from the Henderson office and the Las Vegas Mental Health Outreach office are predominantly in the categories of drug addiction and "other mental" disorders of character, personality, or behavior, while no other office has more than one rehabilitated drug addict.

The reasons for non-acceptance of referrals and nonrehabilitation of mentally disabled clients are not what one might expect. Only small fractions of referrals are reported to be unqualified for service, i.e., have too severe a disability, no disabling condition, or no vocational handicap. Over 80 percent of those not accepted for service were dropped because the agency was unable to locate or contact the applicant, the applicant had moved, the applicant refused service or failed to cooperate, or for some "other" reason. Similarly, the prime reason for nonrehabilitation of mentally disabled clients after acceptance into the program is that three-fourths of the nonrehabilitants "drop out," i.e., cannot be located or contacted, move, refuse further service, or do not cooperate.

In terms of economic benefit, which is only the most readily measurable one of the various types of benefits resulting from the VR program, the results are gratifying. Only 22 percent were gainfully employed at referral and the combined annualized earnings of mentally disabled rehabilitants amounted to \$330,000 at time of referral; that figure rose to \$1,820,000 at time of closure. The percentage of rehabilitants on public assistance dropped from 23 percent at referral to 1 percent at time of case closure. Average weekly earnings upon closure were \$105, but one-third earned less than \$80 per week and only 4 percent earned over \$200 per week. That is, mentally disabled rehabilitants are being placed in relatively low-paying jobs, the majority in the service, clerical, and sales fields, and many of them may be underemployed relative to their abilities.

Our economic benefit/cost analysis of the VR program presented later in this chapter indicates that this program appears to yield economic benefits to taxpayers who are paying for the vocational services to mentally handicapped people (reduced service cost later in the mentally handicapped people's lives, reduced welfare, and increased taxes paid by the mentally handicapped people) that exceed the costs of the program. The benefits to society as a whole are even larger than they are for taxpayers. (By society, we mean all nonhandicapped and handicapped Nevadans

considered as a group, including both the mentally handicapped people being served and the taxpayers who are paying for the service.) We analyzed the sensitivity of economic benefits and costs to variations in the data and assumptions, and even with what we consider to be a demanding test using very conservative assumptions, the VR program still appears to offer economic benefits to both society as a whole and to Nevada taxpayers that exceed the costs for all eight categories of prevalent mental disabilities analyzed. Thus, the VR program appears justified on its economic benefits alone. Add the enhanced quality of life of the mentally disabled people served—an important consideration—and the VR program is all the more laudable.

Several private community vocational centers receive partial funding from the Community Training Center program in the state Division of Mental Hygiene and Mental Retardation, and partial funding from the VR program. These centers provide a variety of services to preschool children and to adult developmentally disabled (primarily, mentally retarded) people for whom there is no other appropriate prevocational or vocational service program. A total of about 180 adults are served by a full-time-equivalent staff of about 70 and a budget of approximately \$900,000 in FY 1974. The largest two centers are run by the Opportunity Village Association for Retarded Citizens in Las Vegas and the Washoe Association for Retarded Citizens in Reno. They provide services such as work evaluation, work activity, work adjustment and training, counseling, and sheltered employment. Five other small centers in less densely populated areas of the state provide a limited range of prevocational or vocational services to retarded adults. While the number of people served per capita is about the same for each of the three major geographic areas of the state, the larger-scale programs possible in Reno and Las Vegas enable professional personnel to provide a broader range of prevocational and vocational services. While providing greatly needed services, some of these centers are somewhat thin on professional vocational service staff. However, these private programs have been in a stage of rapid growth, and the clients and their families we spoke with in the larger two centers appear quite satisfied with the services.

A small Vocational Training program is operated by the Division of Mental Hygiene and Mental Retardation for about 20 retarded adults in the Reno area who are functioning at or close to competitive employment levels. With an annual budget of \$36,000, the staff of four, none of whom has prior professional vocational service training or experience, provide services in conjunction with the VR program. In 1974, the Vocational Training staff provided vocational evaluation, job placement, and typically about four workweeks of on-the-job training over a period of six calendar weeks. Since 1974, there has been a shift toward providing pre-workshop services.

The special Vocational Education program expends just over \$200,000 with a staff of about 12 full-time-equivalent people at the county school district level. They serve approximately 400 mentally handicapped youth, most of whom are educable mentally retarded. We were unable to learn of any nonretarded youth with serious emotional disturbances who receive special vocational education services. Funds are about half federal and half state and local combined. Vocational or career education through the schools is not well developed even for "normal" youth, and the options available to educable mentally handicapped youth through this program appear very limited. For trainable or more severely mentally retarded youth, and for seriously emotionally disturbed youth, the special vocational education options appear

nonexistent, with the notable exception of the Helen J. Stewart School for retarded youth in Las Vegas. Insufficient attention is paid to coordination with the VR program in some counties. For example, Reno area school personnel have virtually no contact with VR personnel; hence, identified mentally handicapped adolescents are not served by the VR program before completion of school, and usually not after.

The Department of Employment Security primarily provides unemployment compensation plus, through its employment services division, services such as job information and placement to unemployed people. The Department spent at least \$32,000 in FY 1974 providing employment services such as job information and placement service to the 337 mentally handicapped adults it reported serving. More mentally handicapped people may be served by this program, but were not reported as such on the client forms. Of these 337 people, 82 were placed in jobs, 8 were enrolled in training, 66 were provided counseling, 84 were referred to other training programs, and 30 were referred to supportive services (which includes referrals to the Bureau of Vocational Rehabilitation). It appears that most of the mentally handicapped people served are served by ES personnel without specialized knowledge of the vocational abilities of mentally handicapped people. Employment Security personnel are also reported to have a tendency to give lower priority to people they think will have a harder time getting jobs.

The next several sections of this chapter provide a more detailed description and analysis of vocational service programs for mentally disabled Nevadans.

VOCATIONAL REHABILITATION PROGRAM

The Nevada Bureau of Vocational Rehabilitation (VR) plays the major operating role for this program, within the Division of Rehabilitation in the Department of Human Resources.¹ The stated goal of the Rehabilitation Division is "to provide to all Nevadans who need them rehabilitation and habilitation services in the most coordinated, efficient, and expeditious manner possible."² The direction of the VR Bureau's program is based on the following philosophy: "Every member of a democratic society has an inherent right to the opportunity to earn a living, and make his contribution to society. Society has the obligation to equalize, as best it can by special services, the disabled person's opportunity to earn a living equal to the opportunity possessed by the nondisabled members of the society."³ Nevada State VR personnel directly provide certain services such as counseling and placement, and purchase others such as medical services and vocational training from public and private vendors.

The present role of the Federal Government is also major. It funds 79 percent of the VR program in Nevada; supports services to all types of physically or mentally disabled persons with substantial handicaps to employment but with "high" vocational potential; allows provision of virtually any service that a client might need;

¹ Other portions of the Division of Rehabilitation are not concerned primarily with vocational rehabilitation. They include the Developmental Disabilities Program and the Bureaus of Services to the Blind, of Alcohol and Drug Abuse, and of Disability Adjudication (determination of eligibility for the Social Security programs).

² *Biennial Report (FY 1973-74)*, Rehabilitation Division, Nevada Department of Human Resources, 1975.

³ *Ibid.*

and supports research, the construction of physical plants, and the training of professional personnel. Thus, the Nevada Bureau of VR is responsible for providing services under broad federal guidelines and primarily with federal funds.

The Nevada-federal VR program objective is strictly vocational, to help physically or mentally handicapped persons to obtain gainful employment and lead meaningful lives. They may be provided "any goods and services necessary to render them fit to engage in a gainful occupation. . . ." The handicapped person served, however, must have a "substantial handicap to employment, which is of such a nature that vocational rehabilitation services may reasonably be expected to render him [or her] fit to engage in a gainful occupation, including a gainful occupation that is more consistent with his [or her] abilities and capabilities." That is, the person must need the services and have reasonable potential to benefit from them. A person may also be served to evaluate his or her rehabilitation potential. The term "gainful occupation" is interpreted broadly to include "employment in the competitive labor market; practice of a profession; farm or family work . . . ; sheltered employment; and home industries or other gainful homebound work."⁴

The Federal Rehabilitation Act of 1973⁵ revised the VR program but did not change its basic aspects. The emphasis of the program's objective was shifted, however, toward serving first those persons with the most severe handicaps. With the exceptions of alcoholism and drug abuse, some people in each of the various types of mental disabilities considered in this chapter fall within the federal definition of a severe handicap.⁶

The Nevada Bureau of Vocational Rehabilitation had offices throughout the state in 1974. They were located in Carson City (one general and one public offender outreach office for criminal justice system clients), in the Reno area (one general and one Nevada Mental Health Institute office), in the Las Vegas area (one general, one mental health center outreach, and one public offender outreach office), and in Elko, Ely, Henderson, and Winnemucca. With the exception of the three general offices in Carson City, Reno, and Las Vegas, these offices typically have a total staff of three or four people in each.⁷ The total authorized VR staff in all offices numbered 80.3 full-time-equivalents in FY 1974.⁸ At the large Reno and Las Vegas offices, the bureau operates two vocational evaluation and work adjustment centers with staffs of 10 to 15 at each center. Both centers are accredited by the National Commission on Accreditation of Rehabilitation Facilities.⁹ These two VR centers, plus the Washoe Association for Retarded Citizens and Opportunity Village programs for

⁴ *Federal Register*, Vol. 34, No. 200, October 1969.

⁵ P.L. 93-112, approved September 26, 1973.

⁶ As specified in the Act, the term "severe handicap" means a disability that seriously limits functional capabilities in terms of employability, that requires multiple services over an extended period of time, and that results from amputation, blindness, cancer, cerebral palsy, cystic fibrosis, deafness, heart disease, hemiplegia, mental retardation, mental illness, multiple sclerosis, muscular dystrophy, neurological disorders (including stroke and epilepsy), paraplegia, quadriplegia and other spinal cord conditions, renal failure, respiratory or pulmonary dysfunction, and any other disability specified by the Secretary of HEW in regulations he shall prescribe.

⁷ Interview with Lloyd Mack, Jr., Deputy Administrator, Nevada Rehabilitation Division, Carson City, Nevada, May 9, 1974.

⁸ *The Executive Budget, State of Nevada, Fiscal Years 1975-76 and 1976-77*, Office of the Governor, Carson City, Nevada, January 20, 1975. Hereafter cited as *The Executive Budget*. For lack of better data, we assume in the summary table at the beginning of this chapter that employees are distributed by handicap in the same proportion as VR case service expenditures.

⁹ *Biennial Report (FY 1973-74)*.

developmentally disabled people, are the only vocational evaluation and work adjustment centers in the state. The smaller rural VR offices provide job counseling and placement, but for services such as work evaluation, work adjustment, and specialized medical evaluation, clients are sent to either Reno or Las Vegas. Of the FY 1974 mentally disabled rehabilitants, 20 and 49 percent were served at the VR program's vocational evaluation and work adjustment centers in Reno and Las Vegas, respectively.

A caution is in order concerning the meaning of some key statistics cited in the Bureau of Vocational Rehabilitation's FY 1973-74 *Biennial Report*, since statistics to be presented later in this chapter are significantly different. The *Biennial Report* indicates 9815 Nevada residents were "served" by the Bureau of Vocational Rehabilitation in FY 1973-74, with 1733 physically and/or mentally handicapped persons being rehabilitated. Our analysis of the data indicates that there were 7337 case closures in the two-year period, including referrals that were not accepted for service, and that the median service time was less than one year. If the number of active cases at the end of the year were added, then the total would approach the 9815 figure used by VR. Thus, the Bureau's report counts referrals not accepted as clients in the definition of "served," whereas we do not do so in this chapter.

In the following subsections, we are able to present detailed information on VR services to persons with various types and degrees of mental disabilities because the VR program maintains a much more comprehensive and usable management information system than do any of the other major programs we analyzed.

Nevada's Vocational Rehabilitation Caseload, FY 1974 Closures¹⁰

In this chapter we define disabilities as the Nevada Division of Rehabilitation does,¹¹ under guidelines provided by the U.S. Rehabilitation Services Administration. We include in the term "mental disability" all disabilities the Division of Rehabilitation lists as "Mental, Psychoneurotic, and Personality Disorders," including alcoholism, drug addiction, mental retardation of various degrees of severity, psychotic and psychoneurotic disorders, and other mental disorders of character, personality, and behavior. Definitions of handicaps given in the Nevada State Rehabilitation Division's *Rehabilitation Services Manual* are grouped in this report as follows:

Alcoholism (Code 520)

Drug Addiction (Code 521)

Mental retardation (MR) is subjectively defined as "subaverage intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior," which may be reflected in impairment of maturation, learning, or social adjustment. Subaverage intellectual functioning is further defined as an IQ of about 85 or less on an individual test, although

¹⁰ Data presented on mentally disabled persons have been computed at The Rand Corporation from FY 1974 "Case Service Reports," U.S. Department of Health, Education, and Welfare Form RSA-300, completed by the Nevada Division of Rehabilitation on each applicant at the time of case closure. To protect confidentiality, data that would permit the identification of individual persons were deleted from the computerized data file.

¹¹ *Rehabilitation Services Manual for Case Finding and Intake, Case Reporting, Client Service Funding*, Secs. 2.330, 2.331, November 1970.

the presence of "maladaptive behavior" must also be established and is "particularly important in determining whether an individual who achieves an IQ in the 70-85 range may or may not be classified as mentally retarded." Three levels are described:

- Mild MR: Persons who, with the provision of appropriate rehabilitation services, can become capable of independent living in the community and engage in competitive employment. Generally, they will require supervision and guidance only under conditions of particular social or economic stress. (Code 530)
- Moderate MR: Persons capable of maintaining themselves in the community and performing adequately in low-demand competitive employment, but who will require continuing supervision and assistance in the management of personal affairs. (Code 532)
- Severe MR: Persons capable of productive work but only under sheltered, non-competitive conditions in a protective environment. (Code 534)

Psychotic Disorders (Code 500)

Psychoneurotic Disorders (Code 510)

Other Mental Disorders (character, personality, and behavior) (Code 522)

Epilepsy (Code 630)

Cerebral Palsy (resulting in orthopedic deformity or functional impairment) (Codes 300, 320, 340, 360, 380)

Parkinson's Disease (resulting in orthopedic deformity or functional impairment) (Codes 317, 337, 357, 377, 397)

Stroke (intracranial hemorrhage, embolism, and thrombosis resulting in orthopedic deformity or functional impairment) (Codes 312, 332, 352, 372, 392)

In this chapter, we also include in the term "mental disability" certain mentally related disorders such as epilepsy, cerebral palsy, Parkinson's Disease, and stroke that the Division of Rehabilitation lists under "orthopedic deformity or functional impairment" or under "other disabling conditions."¹²

In analyzing data on the VR program by type of mental handicap, with the exception of those applicants not accepted, we used the "major disabling condition" at the time the person was accepted for extended evaluation or rehabilitation services, as determined by Bureau of Vocational Rehabilitation personnel "from the most recent document or documents prepared by physicians based on the examination of the client, and/or medical records of a hospital or clinic where the client was examined."¹³ For persons not accepted for extended evaluation or rehabilitation, we used the "reported disabling condition" given to the Division at the time of referral.

Since the VR program serves people with many different types of mental disability of vastly diverse natures and severities, ranging from alcoholics to psychotics to criminal offenders with "character" disorders, we will disaggregate most of the information presented by type of mental disability so that a more accurate picture is obtained. However, the imprecision with which the VR program defines the various types of mental disabilities does not permit an entirely clear picture. Impre-

¹² Ibid.

¹³ Ibid., Sec. 2.3310.

cise definition also affords VR personnel a great deal of latitude in selecting clients they want to accept into this service program.

Data available and presented describe the FY 1974 case closures only. Thus, data such as expenditures for active cases not closed during that year are excluded; however, data such as expenditures for the FY 1974 closures include expenditures incurred in previous years if the case was open prior to FY 1974. In short, the data we present do not cover everything the program did in FY 1974, but rather deal with a group of referrals and clients whose cases were closed in FY 1974.

In the tables to follow, care must be taken in interpreting data given in percentages for individual types of mental disabilities. For example, only one person with Parkinson's Disease applied; that person was accepted for service but not rehabilitated, and hence a table would record a 100-percent failure rate for Parkinson's Disease clients—clearly not a representative rate.

Of the 3205 case closures in FY 1974, including those referred but not served, 1520 (47 percent) had or reportedly had mental disabilities. Of the 1431 FY 1974 closures for people accepted into the VR program, 678 (again 47 percent) were diagnosed as mentally disabled. And of the 824 persons successfully rehabilitated, 334 (41 percent) were mentally disabled, as seen in Table 11.3. (Here, successful rehabilitation means that both the client and employer gave a favorable employment prognosis after a month on the job.) The Nevada VR program's rate of acceptance for service of physically disabled persons (45 percent) was the same as that of mentally disabled persons. However, the program was considerably more successful in vocationally rehabilitating physically disabled persons (65 percent) than it was for mentally disabled persons (49 percent). Even so, the rehabilitation of nearly half of the latter is a laudable program achievement.

The current VR rule concerning classification of the mental disability of clients is that a medical doctor or a psychologist must make the determination. Clients are supposed to be classified psychotic or neurotic only by a psychiatrist or by a psychologist with a Ph.D. degree. Clients are supposed to be classified as mentally retarded or "other mentally disabled" only by a psychiatrist or by a psychologist with a master's degree or Ph.D.¹⁴

Considering the clientele by type of mental disability, Table 11.3 indicates a very heavy emphasis on people who have "other mental disorders" of character, personality, or behavior and therefore are not psychotic, neurotic, retarded, alcoholic, or addicted to drugs by VR program definitions. Of those accepted for service, 39 percent have what the VR program calls "other mental disorders," and accounted for over 49 percent of the FY 1974 closed cases expenditures for mentally disabled persons. In comparison, only 12 percent of those mentally disabled persons accepted were retarded. Of course, it is possible that many persons recorded as having "other mental disorders" actually suffered from psychosis or retardation, but that it was more expedient for the rehabilitation counselor to classify them "other mental" than to obtain the higher-quality professional psychological evaluation necessary to justify a more specific mental disability classification. While there is merit to the argument that "it's the service that counts, not the classification," the failure to obtain a higher-quality professional psychological evaluation may result in inadequate or inappropriate service.

¹⁴ Interview with Lloyd Mack, Jr.

Table 11.3

VOCATIONAL REHABILITATION BY TYPE OF MENTAL DISABILITY, FY 1974 CLOSURES

Type of Disability	Referred for Service		Accepted for Service		Successfully Rehabilitated		Accepted as Percent of Referred	Rehabilitated as Percent of Accepted	Percent of Expenditures on Mental Disability Group
	No.	%	No.	%	No.	%			
Alcoholism	160	11	76	11	36	11	48	47	6.0
Drug addiction	114	8	64	9	46	14	56	72	7.6
MR, mild	87	6	54	8	37	11	62	69	5.1
MR, moderate	41	3	24	4	14	4	59	59	1.4
MR, severe	8	0.5	3	0.4	1	0.3	38	33	0.1
Psychotic	214	14	77	11	20	6	36	26	7.1
Psychoneurotic	107	7	84	12	37	11	79	44	17.5
Other mental disorder	708	47	263	39	124	37	37	47	49.9
Epilepsy	56	4	23	3	13	4	41	56	2.8
Cerebral palsy	9	0.6	4	0.6	3	0.9	44	75	1.2
Parkinson's disease	1	0.0	1	0.2	0	0.0	100	0	0.5
Stroke	15	1	5	0.7	3	0.9	33	60	0.7
Total, all disabilities	3205		1431		824		45	58	
Total, mental disabilities	1520	100	678	100	334	100	45	49	100

SOURCE: Rand analysis of FY 1974 "Case Service Reports."

NOTE: Percentages may not add to 100 because of rounding.

VR Expenditures for Mentally Disabled People, FY 1974

In FY 1974 the Bureau of Vocational Rehabilitation expended \$3,034,000 on behalf of all types of physically and mentally disabled people. Of that sum about 79 percent came from federal sources (see Table 11.4).¹⁵

We estimate that \$1,566,000 was for mentally disabled people.¹⁶ Of that total, \$483,000 was for improvement of programs and facilities for the developmentally disabled population operated by Opportunity Village in Las Vegas, the Washoe Association for Retarded Citizens in Reno, and the Ormsby Association for Retarded Citizens in Carson City; an estimated \$334,000 was for the cost of services purchased;¹⁷ and the remainder was for the cost of state rehabilitation counselors and for operation of the Bureau of Vocational Rehabilitation (see Table 11.4 for a breakdown by type of expenditure).

As shown in Table 11.5, the estimated total VR expenditures for mentally disabled clients whose cases were closed in FY 1974 was \$794,000. An explanation of the difference between this figure and others on the VR program is in order. As

¹⁵ The Nevada Rehabilitation Division costs of administration (above the bureau level) were about \$368,000 in FY 1974 and were paid by reimbursement from each of the Bureaus within the Division. Thus, for example, the expenditures for the Bureau of Vocational Rehabilitation include approximately \$226,000 listed under "other operating expenses," to pay for division administration costs above the bureau level.

¹⁶ We assume that, with the exception of the University of Nevada grant, all grants to local projects shown in Table 11.4 are for the mentally disabled population and that, for lack of better data, all other FY 1974 VR expenditures are distributed by type of disability in the same proportions as "cost of services" are distributed by type of disability for FY 1974 case closures.

¹⁷ Assuming that, for lack of better data, the total FY 1974 VR costs of services purchased are distributed by type of disability in the same proportions as costs of services are distributed by type of disability for FY 1974 case closures.

Table 11.4

**FUNDS AVAILABLE TO AND EXPENDED BY THE NEVADA BUREAU
OF VOCATIONAL REHABILITATION, FY 1974**

I. Funds available: \$3,175,000		
Federal		79%
State		19
Other		2
Total funds available		100
II. VR expenditures: \$3,034,000		
Personnel expenses		29
Travel		1
Other operating expenses		20
Capital outlay, equipment		2
Cost of services purchased		26
Client payroll		2
Employee training		1
Facility equipment		3
Grants to local projects:		
Opportunity Village	\$221,000	
Ormsby Assn. for Retarded Citizens	15,000	
Univ. of Nevada, Reno: Gallup Poll	31,000	
Washoe Assn. for Retarded Citizens	247,000	
Total grants to local projects (%)		16
Total VR expenditures		100

SOURCE: "1973-74 Actual (Expenses and Revenues)-Vocational Rehabilitation (Account 101-3265)," provided by Nevada Division of Rehabilitation, February 1975 (mimeograph).

NOTE: These figures do not include expenditures of FY 1974 funds made after January 1975.

Table 11.5

**VR PROGRAM EXPENDITURES FOR MENTALLY DISABLED CLIENTS,
FY 1974 CLOSURES ONLY**

Type of Disability	Total Cost of Services	Estimated Expenditures ^a	Average Expen- ditures per Person		Percent of Expenditures Incurred	Average Cost of Services per Person		Percent of Rehabilitants for Whom Cost of Services Was:	
			Accepted	Rehab.		Accepted	Rehab.	Under \$100	\$1000 or More
Alcoholism	14,760	48,000	626	1,323	6	194	410	58	3
Drug addiction	18,641	60,000	939	1,306	8	291	405	35	2
MR, mild	12,461	40,000	742	1,087	5	230	337	51	5
MR, moderate	3,487	11,000	468	803	1	145	249	43	0
MR, severe	255	<1,000	274	823	<1	85	255	0	0
Psychotic	17,542	57,000	735	2,829	7	228	877	35	10
Psychoneurotic	43,115	139,000	1,654	3,758	18	513	1,165	24	14
Other mental disorder	122,896	396,000	1,506	3,197	50	467	991	28	21
Epilepsy	6,921	22,000	971	1,716	3	301	532	46	15
Cerebral palsy	2,898	9,000	2,339	3,116	1	725	966	0	33
Parkinson's disease	1,338	4,000	4,316	NA	<1	1,338	NA	NA	NA
Stroke	1,751	6,000	1,129	1,880	<1	350	583	0	0
Total, all disabilities	586,160	1,891,000	1,323	2,294	NA	410	711	27	13
Total, mental disabilities	246,065	794,000	1,168	2,374	100	362	736	35	12

SOURCE: Rand analysis of FY 1974 "Case Service Reports."

NOTES: Columns may not total to 100 because of rounding. NA = not applicable.

^a Assumes that the average of 31 percent of total VR expenditures (exclusive of grants to local projects) for the cost of services to individuals holds for each disability group. Note that the estimates here are for expenditures over the entire active case life of FY 1974 case closures, not FY 1974 expenditures.

mentioned before, this amount includes expenditures made prior to FY 1974 on clients whose cases were closed in FY 1974, and excludes expenditures during FY 1974 for clients whose cases were still open at the end of the fiscal year. The estimated cost of services purchased in FY 1974 for all mentally disabled clients was \$334,000; the estimated cost of services purchased in all years for mentally disabled clients whose cases were closed in FY 1974 was \$246,065. When we divided those figures by the numbers of clients, we found that per-client expenditures were lower for case-closure clients. Probably, most of that difference was attributable to a rapid increase during FY 1974 in the cost of services purchased, which would make cases still active at the end of the year show a higher average cost. The Nevada Division of Rehabilitation has documented the rapid increase in the average cost of services per client from FY 1973 to FY 1974.¹⁸ It is speculated that the increase is due to the combined effects of inflation, a shift during FY 1974 to serving more severely disabled individuals as mandated by the Federal Rehabilitation Act of 1973,¹⁹ and a possible tendency to keep clients on the active caseload longer because of difficulties in placing them in jobs during an economic recession.

Nationwide, in FY 1971, the cost of services purchased was 56 percent of the total basic program cost; the comparable figure for Nevada was the lowest of any state, 29 percent.²⁰ In FY 1974 in Nevada, the cost of services purchased was 31 percent of the VR expenditures exclusive of grants to local projects.

For purposes of making comparisons across different types of disabilities, Table 11.5 is a breakdown of expenditure data by type of disability for FY 1974 case closures. Mentally disabled clients accounted for 47 percent of the case closures, and for about 42 percent of the cost of services purchased for all physically and mentally disabled clients. Estimated average total expenditures were \$1168 per mentally disabled person accepted and \$2374 per person successfully rehabilitated. The average cost of services purchased per mentally disabled person rehabilitated was \$736 (slightly more than the \$711 average for all types of rehabilitants). Figure 11.2 shows the distribution of the cost of services to mentally disabled rehabilitants. Note that about one-third receive less than \$100 in purchased services while only 12 percent receive \$1000 or more. Thus, funds generally are not going for extensive and expensive types of vocational training. It also can be seen from Fig. 11.2 that the mentally retarded rehabilitant generally receives significantly less costly services than rehabilitants with other types of mental disabilities. The reasons are not clear. Is it that, compared with people with all other types of mental disabilities combined, retarded people are easier and hence less costly to train vocationally or place in jobs? Are retarded people being placed in low-skill occupations rather than being allowed to develop more of their potential abilities? (As shown elsewhere in this chapter, retarded clients are much more likely to be placed in very low-paying service jobs than are other types of mentally disabled clients.) Or do retarded clients receive more vocational services not directly provided by the Bureau of Vocational Rehabilitation for their specific case? (E.g., local project grants funded by VR are clearly contributing significantly to the rehabilitation of individual clients, and private

¹⁸ Unpublished study by Jean Wilcher, Nevada Division of Rehabilitation, 1975.

¹⁹ P.L. 93-112, approved September 26, 1973.

²⁰ U.S. Department of Health, Education, and Welfare, *State Vocational Rehabilitation Agency: Program Data FY 1971*, Social and Rehabilitation Service, DHEW Publication No. (SRS) 72-25016, March 1972.

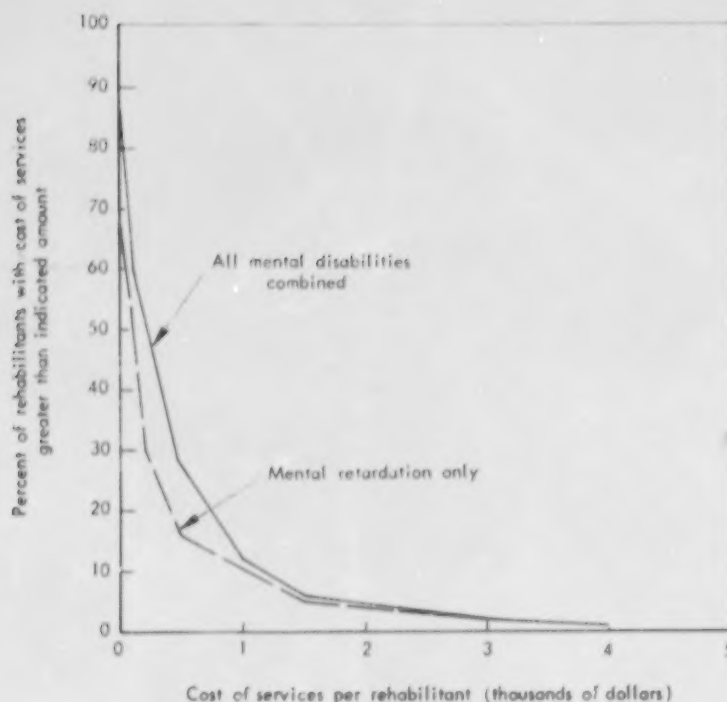


Fig. 11.2—Cost of services for rehabilitated mentally disabled VR clients, FY 1974 closures

employers may be more willing to provide "free" on-the-job training for retarded people than for other types of mentally disabled clients.) Although the various categories of mentally disabled clients do not require the same types and amounts of services on the average, the variation in cost of services among those categories shown in Table 11.5 should have a perceptible relationship to variation in need. We were unable to perceive a consistent relationship. Even if we exclude categories containing very few people (and hence subject to great variation in average costs due to the unique needs of the small number of clients), we still see variations in average cost that require explanation. Why are the highest average expenditures per rehabilitant found in the psychoneurotic and the nebulous "other mental disability" categories? Taken as a whole, people in those two categories are certainly not the most severely handicapped, or the hardest to train and place in jobs. Contrary to what might be expected and desirable, the average expenditures per client accepted decrease as the severity of the mental handicap increases, e.g., from \$742 per mildly retarded client to \$468 per moderately retarded client, and from \$1654 per neurotic client to \$735 per psychotic client.

Vocational Rehabilitation Program Growth

In terms of both expenditures and the total number of physically and mentally

disabled persons rehabilitated, the VR program approximately doubled in the three years from FY 1971 (458 rehabilitations and expenditures of \$1.5 million²¹) to FY 1974 (824 rehabilitations and expenditures of \$3.0 million²²). However, all of that growth took place between FY 1971 and FY 1973 and the total number of rehabilitations actually declined slightly from 909 in FY 1973 to 824 in FY 1974.

Total fiscal year expenditures per rehabilitant show just over 3 percent per year "inflation" from \$3350 per rehabilitant in FY 1971 to \$3680 in FY 1974.

Over recent years the number of mentally disabled rehabilitants has changed much the same as has the number of rehabilitants with all types of disabilities. The number of mentally disabled rehabilitants grew rapidly from FY 1971 through FY 1973 and then leveled off, so that FY 1974 was nearly the same as FY 1973 in terms of successful rehabilitations (see Table 11.6). This pattern of growth has not been the same for all types of mental disabilities, however. The number of alcoholics and

Table 11.6

NUMBERS OF REHABILITATED CLIENTS WITH VARIOUS MENTAL
DISABILITIES, FY 1971-FY 1974 CLOSURES

Disabling Condition	Number of Rehabilitated Clients				Percent Increase, FY 1973-74 Over FY 1971-72
	FY 1971 and FY 1972 Combined ^a	FY 1973 ^b	FY 1974 ^b	FY 1973 and FY 1974 Combined	
Alcoholism	44	36	36	72	64
Drug addiction	10	8	46	54	440
Epilepsy	9	9	13	22	144
Mental retardation	51	50	52	102	100
Psychotic-psychoneurotic disorders	97	60	57	117	21
Personality and behavior disorders	210	156	124	280	33
Total	421	319	328	647	54

^aNevada Rehabilitation Division, *Biennial Report*, Carson City, Nevada, January 1, 1973.

^bRand analysis of FY 1973 and FY 1974 "Case Service Reports."

mentally retarded persons served approximately doubled from FY 1971 to FY 1973 and then held relatively constant from FY 1973 to FY 1974. On the other hand, the number of rehabilitants with psychotic or psychoneurotic disorders grew only slightly over the three-year period, while the number of drug abusers rehabilitated climbed nearly tenfold from a very small base. The number of rehabilitants with personality and behavior disorders grew more slowly than the number with alcoholism or retardation disabilities from FY 1971 to FY 1973, and then declined about

²¹ Nevada Rehabilitation Division, *Biennial Report*, Carson City, Nevada, January 1, 1973.

²² "1973-74 Actual Expenses and Revenues—Vocational Rehabilitation (Account 101-3265)," provided by Nevada Division of Rehabilitation, February 1975 (mimeograph).

20 percent from FY 1973 to FY 1974, indicating a shift in relative program emphasis toward other types of disabled people last year.

VR Service by County and District Office

Table 11.7 shows the distribution of the mentally disabled VR caseload across Nevada by county of residence. Clark County has 56 percent of the population but, exclusive of Nevada Mental Health Institute (NMHI) residents,²³ accounts for only 35 percent of the VR referrals of mentally disabled persons, 39 percent of the clients served, and 49 percent of the rehabilitations. Washoe County (exclusive of NMHI) has 24 percent of the population, 19 percent of the referrals, 20 percent of the clients served, and 19 percent of the mentally disabled rehabilitants in FY 1974. All other counties except Clark and Washoe account for almost 20 percent of the state's population, 22 percent of the referrals of mentally disabled people (exclusive of NMHI residents), 18 percent of those served, and 16 percent of those rehabilitated. A mentally disabled person who is referred from any of the three major areas of the state has a relatively better chance of being accepted if he or she is from Clark or Washoe Counties rather than from the combined rural counties. However, the chance of a resident (exclusive of NMHI residents) being referred in the first place is highest in the rural counties: 1.7 reportedly mentally disabled persons referred per 1000 total population in Clark County; 2.1 per 1000 in Washoe County; and 3.2 per 1000 in all other counties combined. Once accepted, the mentally disabled client has a considerably better chance of being rehabilitated in the Las Vegas area (62 percent) than in the Reno area (47 percent) or rural area (42 percent). However, the total number of mentally disabled rehabilitants is approximately 0.5 per 1000 total population in each of the three areas. Looking at the number of mentally disabled persons rehabilitated from a geographic area in relation to the total number of physically and mentally disabled rehabilitants from that area shows a low emphasis on the mentally disabled in Las Vegas in relation to the rest of the state; 30 percent of the rehabilitants from Clark County were mentally disabled, while the comparable figures from Washoe and the other counties combined were 49 and 53 percent, respectively. A 1974 Nevada survey of activity limitations and work interference due to a mental condition showed that Clark County may have a *higher* prevalence rate per capita than Washoe and rural counties.²⁴ In the geographic area outside Clark and Washoe Counties, mentally disabled people in several counties were markedly underserved in FY 1974 relative to the rest of the state. For example, in Esmeralda, Eureka, Nye, and Storey Counties combined, only two mentally disabled persons were served and neither was rehabilitated.

Table 11.7 also presents data by VR district office providing the referral. The Reno area office has the largest number of mentally disabled persons referred and accepted, and the Mental Health Institute is a close second.

Table 11.8 presents distribution across the state of mentally disabled people who were successfully rehabilitated. Note the tendency of offices to "specialize" in certain disabilities. Rehabilitants from the Henderson office and the Las Vegas

²³ NMHI residents who are rehabilitated are recorded in the VR program as Washoe County residents (interview with Lloyd Mack, Jr.). We have excluded them from the Washoe County figures in this analysis because they are drawn from all parts of the state.

²⁴ "Survey of Nevada Rehabilitation Needs, 1975: Synopsis," Nevada Rehabilitation Division, March 1975.

Table 11.7

**VOCATIONAL REHABILITATION CASELOAD OF MENTALLY HANDICAPPED PERSONS,
BY COUNTY AND DISTRICT OFFICE, FY 1974 CLOSURES**

County or District Office	Referred	Accepted	Rehabili- tated	Number Rehabili- tated per 1000 Population ^a	Accepted as Percent of Referred	Rehabili- tated as Percent of Accepted	Mentally Handicapped Persons Rehabilitated as Percent of All Persons Rehabilitated
County							
Carson City	82	41	20	1.0	50	49	65
Churchill	20	5	1	0.1	25	20	33
Clark	532	263	162	0.5	49	62	30
Douglas	9	3	1	0.1	33	33	20
Elko	90	24	5	0.3	27	21	45
Emeralda	4	2	0	0.0	50	0	NA
Eureka	2	0	0	0.0	0	NA	NA
Humboldt	49	11	8	1.2	22	73	47
Lander	12	2	1	0.4	17	50	20
Lincoln	17	16	3	1.3	94	19	60
Lyon	9	4	1	0.1	44	25	100
Mineral	10	3	2	0.3	30	67	50
Nye	4	0	0	0.0	0	NA	0
Pershing	6	1	1	0.2	17	100	100
Storey	1	0	0	0.0	0	NA	NA
Washoe (except Mental Health Institute)	296	137	65	0.5	46	47	49
White Pine	22	12	9	0.8	55	75	64
California counties	1	0	0	0.0	0	NA	NA
Mental Health Institute	364	154	55	NA	42	36	96
All counties except Clark and Washoe	338	124	52	0.5	37	42	53
District office							
Carson City	50	26	13	NA	52	50	38
Elko	84	23	6	NA	27	26	46
Ely	31	22	9	NA	71	41	56
Henderson	71	35	29	NA	49	83	21
Las Vegas Area	229	83	51	NA	36	61	18
L.V. Mental Health Outreach	182	129	82	NA	71	64	76
Mental Health Institute	364	154	55	NA	42	36	96
Public Offender Outreach							
Carson City	84	29	9	NA	35	31	100
Las Vegas	4	0	0	NA	0	NA	0
Reno Area	366	166	70	NA	45	42	51
Winnemucca	55	11	10	NA	20	91	48
Total, district offices	1520	678	334	0.6	45	49	41

SOURCE: Rand analysis of FY 1974 "Case Service Reports."

NOTE: NA = not applicable.

^aBased on 1970 Census of Population Data projected to 1974 by Prof. S. F. Chu, "Nevada County Population Estimates," Bureau of Business and Economic Research, University of Nevada/Reno, October 1973.

Table 11.8
SUCCESSFULLY REHABILITATED MENTALLY HANDICAPPED PERSONS IN VARIOUS
HANDICAP GROUPS, BY AREA OF STATE AND DISTRICT OFFICE, FY 1974

Area of State or District Office	Alco- holic	Drug Addiction	MR, Mild	MR, Moderate	MR, Severe	Psychotic	Psycho- neurotic	Other Mental Disorder	Epilepsy	Cerebral Palsy	Stroke	All Mental Handicaps Combined
Clark County (Number per 1000 pop.) ^a	12 (0.04)	43 (0.13)	26 (0.08)	5 (0.02)	1 (0.00)	6 (0.02)	13 (0.04)	51 (0.16)	5 (0.02)	0 (0.00)	0 (0.00)	162 (0.51)
Washoe County except MH Institute (Number per 1000 pop.)	3 (0.02)	1 (0.01)	3 (0.02)	1 (0.01)	0 (0.00)	2 (0.01)	14 (0.10)	35 (0.25)	1 (0.01)	2 (0.01)	3 (0.02)	65 (0.46)
All counties except Clark, Washoe (Number per 1000 pop.)	5 (0.05)	1 (0.01)	3 (0.03)	1 (0.01)	0 (0.00)	0 (0.00)	3 (0.03)	31 (0.29)	7 (0.07)	1 (0.01)	0 (0.00)	52 (0.49)
District Office												
Carson City	3	0	1	0	0	0	1	7	1	0	0	13
Eldorado	0	0	1	0	0	0	0	4	1	0	0	6
Ely	0	0	0	0	0	0	0	4	4	1	0	9
Henderson	2	11	2	0	0	0	2	11	1	0	0	29
Las Vegas Area	2	0	23	4	1	1	2	15	3	0	0	51
L.V. Mental Health Institute	8	32	1	1	0	3	9	27	1	0	0	82
Mental Health Institute	16	1	6	7	0	12	7	7	0	0	0	55
Public Offender Outreach												
Carson City	0	1	0	0	0	0	0	8	0	0	0	9
Las Vegas	0	0	0	0	0	0	0	0	0	0	0	0
Reno Area	4	1	4	2	0	4	14	36	1	2	3	70
Winnemucca	1	0	0	0	0	0	2	6	1	0	0	10
Total, District Offices	36	46	37	14	1	20	37	124	13	3	3	334

^aSee Table 11.7 for population data source. Other data are from Rand analysis of FY 1974 "Case Service Reports."

Mental Health Outreach office are predominantly in the categories of drug addiction and "other mental disorders." No other office has more than one rehabilitated drug addict. The NMHI office concentrates most heavily on alcoholism, but also emphasizes psychosis and mental retardation. The Reno area office concentrates on people with psychoneurosis and the nebulous, but most prevalent, "other mental disorder" category.

Detailed VR Client and Program Characteristics, FY 1974 Closures

See Appendix A for a detailed presentation of data on VR program client and program characteristics by type of mental handicap and outcome of the VR services. Topics discussed there include sources of referrals; destinations of persons referred elsewhere by VR; outcomes of referrals to VR and the reasons for nonacceptance of people as clients and for nonrehabilitation of clients; age, sex, race, Spanish surname, education, previous VR service, and secondary disabilities of clients; services provided; time spent in the VR program; client earnings and sources of support at time of referral and time of case closure; and occupations of rehabilitants.

Benefit/Cost Analysis of the Vocational Rehabilitation Program

The analyses in this section concentrate on economic benefits—only one of the various benefits by which the VR program should be evaluated. Earlier in this chapter we presented available data on other classes of criteria, such as the degree of change in clients' dependence and the equity of service distribution. Unfortunately, data are not available for some of the most significant effects, namely, changes in the overall quality of life of the mentally disabled people served. As will be seen, however, this VR program appears justified by its economic benefits *alone*. Other very significant major types of benefits, which are known to be positive but are unquantified, justify this program still further.

It is possible to do a better economic benefit/cost analysis of the VR program than it is for most other programs, because the VR program's data are generally better than those of any other program. In regard to vocational service, for example, only the VR program has data available on work status and earnings both before and after service.

Previous studies have concluded that the nationwide VR program for handicapped persons has yielded benefits that considerably outweigh costs. For example, a 1967 study by the U.S. Vocational Rehabilitation Administration found that each dollar of cost in FY 1966 generated an estimated \$35 in increased clients' earnings and value of work activity over their working lives.²⁵

A more thorough nationwide study, using more realistic assumptions, has been made by Ronald W. Conley.²⁶ His analysis of the VR program focuses on economic

²⁵ U.S. Department of Health, Education, and Welfare, Vocational Rehabilitation Administration, *An Exploratory Cost-Benefits Analysis of Vocational Rehabilitation*, Washington, D.C., August 1967.

²⁶ *The Economics of Vocational Rehabilitation*, The Johns Hopkins University Press, Baltimore, Maryland, 1965; and see idem, "A Benefit-Cost Analysis of the Vocational Rehabilitation Program," *Journal of Human Resources*, Vol. 4, No. 2, April 1969, for one of the best of these benefit/cost studies and a review of others. For citations of other recent analyses, see also J. S. Kakalik et al., *Services for Handicapped Youth: A Program Overview*, The Rand Corporation, R-1220-HEW, May 1973, Chap. 5.

costs and benefits, makes sophisticated use of available data, and clearly states the assumptions used in making estimates. With 1967 data, Conley estimates that for each dollar of the social cost of rehabilitation services, an increase in lifetime earnings of a little less than \$5 accrues (at a 4 percent discount rate on future increased earnings). He also estimates that "the increased taxes paid by the rehabilitants and the reduction in tax supported payments for their maintenance amount to perhaps as much as 25 percent of the total increase in earnings." Critical assumptions underlying these and all other estimates relate to how one estimates what earnings would have been without rehabilitation, and what the employment record of the rehabilitant will be over his lifetime.

A recent Rand Corporation nationwide study of the economic benefit/cost relationships for eight categories of mildly to severely handicapped youth, using more conservative assumptions than those of Conley, found that the VR program for those youth could be justified on its economic benefits alone. In addition, the quality of life benefits are outstanding.²⁷

The following analysis uses Conley's methodology with some significant adaptations. First, previous analyses have generally dealt with the program as a whole, not with disaggregations by type and degree of mental handicap. We will investigate the program's costs and benefits for eight categories of mentally handicapped people (those who are alcoholic, drug-abusing, mildly retarded, moderately retarded, psychotic, psychoneurotic, other mentally disordered, and epileptic) who accounted for 98 percent of the FY 1974 mental rehabilitations. Four categories of mentally handicapped people (those who are severely retarded, or have cerebral palsy, Parkinson's Disease, or stroke) were not separately analyzed, since each had three or less rehabilitants and hence would be subject to large variations in average costs and benefits. Although the VR data excel those for other programs we investigated, benefit/cost analyses must still resort to assumptions where data are incomplete. We will vary certain of those assumptions and note the sensitivity of estimated benefits to the variations.

For a more detailed description of the methodology we are using, the reader is referred to Conley's works, just cited. The methodology is briefly discussed here to lay out its underlying assumptions and mention some of our adaptations. We first describe components of cost, and then discuss the calculation of economic benefits.

Costs. The basic program costs include those of administration, vocational counselors, purchased services, and the establishment and support of rehabilitation facilities and workshops. When considering the effectiveness of the total program, it is possible to use the budget as an indicator of the program cost necessary to achieve that effectiveness. We must try to disaggregate the cost, however, if we want to make distinctions among the groups participating in the program. The only expenditures recorded in a client's file are those for services purchased, such as medical diagnostics, treatment, or vocational training. The agency generally treats the other costs as "overhead" and does not attribute them directly to individual clients. To do an analysis by type of mental handicap, we must devise some means of allocating overhead costs to each type of client. Two possible methods suggest themselves. First, "overhead" costs could be attributed on a per capita basis. This would be an accurate approximation if "overhead" services (e.g., counseling and

²⁷ J. S. Kakalik et al., *Improving Services to Handicapped Children*, The Rand Corporation, R-1420-HEW, May 1974.

guidance) were independent of the length and cost of the service program designed to help the client. Another approach, the one we have adopted, is to allocate all costs in proportion to the costs of services purchased for the individual clients. This implies that the types of clients who receive the most in case services, such as medical treatment and training, also consume a higher proportionate share of counseling and other expenditures. Because high service costs are likely to be associated with the most difficult cases, such an allocation scheme is not unreasonable. Some clients, however, have no "cost of services," and are successfully rehabilitated with, for example, only counseling and placement services from VR agency personnel. Our method implies that these clients actually were served cost-free, and therefore distorts the results somewhat. Because such clients constitute only a small fraction of the total, however, and are distributed across all handicap types, the resultant error is likely to be small. The fraction of the cases with zero cost of services is less than one-sixth for six of the categories of mental disability analyzed, and about one-third for the two mental retardation categories analyzed. Hence, the average total cost estimate for service to mentally retarded people will be biased slightly toward the low side relative to other categories of disability in this benefit/cost analysis.

The cost of income maintenance payments is not counted as a cost to society in the benefit/cost analysis. This stems from the fact that the cost to the group that pays the income transfer payment is equal to the benefits that accrue to the recipients of the income transfer payment; cost and benefits of the transfer cancel each other out when society as a whole is considered if one assumes the marginal value of a dollar to the taxpayer equals the marginal value of a dollar to the person being served. This is not to say that they are cancelled out if we are considering any group *within* society, such as taxpayers. In the case of taxpayers, income maintenance costs would be considered because most recipients of the income transfer payments are not representative taxpayers.

Some clients receive vocational services that are not financed by the VR agency and hence do not show up in the budget of the agency or in the expenditure record of the client. Conley has estimated that such expenditures amounted to 4 percent of the annual program costs, and we use this estimate. We would prefer to add the actual expenditures of other programs for vocational services to VR clients, but the data do not permit this. For example, we do not know how many young mentally handicapped VR clients received vocational education program services nor do we know the cost of Employment Security Department service to mentally disabled VR clients. The one case we know of that is expected to affect the results of this analysis significantly is vocational service provided by the Vocational Training and Community Training Center programs funded by the Division of Mental Hygiene and Mental Retardation and primarily serving moderately retarded individuals who may also be VR clients. Hence the cost estimates in this analysis will be biased to some unknown degree toward the low side for the moderately retarded, and results must be interpreted with that fact in mind.

Some of the clients in the program have previously received service from the VR program. Others will receive additional service in the future. Conley argues that both these past and future costs should be included as part of the incremental social costs for the current year's rehabilitants. We assume, as he did, that the percentage of the year's rehabilitants in each category of disability who would become rehabili-

tation "repeaters" equals the percentage that were repeaters in 1974, and that future service costs are the same as the present average cost of rehabilitation.

This year's clients are also recipients of the benefits of previous national research, staff training, and past expenditures on construction of facilities. These costs must be amortized to get an estimate of the program's true cost. Conley found that public expenditures for these categories were about 20 percent of the annual basic program cost, and that private support in these categories was about 5 percent of basic program cost. This meant that an estimate of the cost of research, training, and construction programs that could be allocated to this year's program would be equal to 25 percent of this year's basic program cost.

One of the social costs of the VR program is the opportunity cost associated with the production that is lost when the client forgoes the labor force and enters the program. Since real data on earnings at acceptance are available, we assume the opportunity cost equals those earnings times the length of time in the VR program.

Benefits. We emphasize that the VR program produces several types of benefits for both the client and society. There are obvious psychic and other benefits to the client, notably self-sufficiency, but in this section we are concerned with the economic benefits that can be attributed to the services provided by the program.

Three major parameters must be specified to find the total increase in earnings from the VR program: the number of years the client will work, the differential in earnings for each year between what he earns after VR services and what he would have earned without them, and the discount rate. The specification or estimation of each parameter is discussed below.

To estimate the number of years worked, Conley assumes that unless the rehabilitant suffers vocational failure or dies, he works until he retires at the age of 65. Conley's mortality rates are taken from experience with Railroad Retirement Disability annuitants. That group has high mortality rates compared with the population in general. We note that the above estimate of number of years worked will include work resulting from future VR service to "repeaters," which is reasonable since our total cost estimate includes the cost of those future "repeat" services. A critical assumption concerns the amount of unemployment later in life. The number of years worked after rehabilitation and before reaching age 65 must be adjusted to reflect periods of possible unemployment. As described in the next section, Conley argues that after five years the decrease in earnings due to unemployment is offset by the increase in productivity (as measured by earnings) of those who retain their employment.

Conley estimates the increased productivity of rehabilitated recipients of VR services as follows:

We will accept our conclusions from the follow-up studies that 80 percent of all rehabilitants are still gainfully employed five years after closure and that their average earnings are about 25 percent higher than the average earnings of rehabilitants in the year of closure, and we will further assume that these successful rehabilitants will continue to be employed at these higher wages until death or retirement. Given these assumptions, it follows that the increase in earnings due to rehabilitation during any time period after rehabilitation will vary with the number of rehabilitants still employed (since the loss of earnings among live rehabilitants of working age who fail to maintain their employment is offset by the increased earnings of successful rehabilitants). Total increased output due to rehabilitants will,

therefore, be equal to the average number of years worked by rehabilitants still employed five years after closure multiplied by the increase in earnings between acceptance and closure.²⁸

A recent follow-up survey of 4146 VR service recipients in six states one, two, and three years after closure, conducted by National Analysts, Inc.,²⁹ suggests that the assumed percentage working five years after closure is too high. Our later sensitivity analysis accordingly considers what the economic benefits would be if the figure were less. The National Analysts report indicates that in the 12 months following closure, 47 percent of the rehabilitants worked without interruption, 29 percent did not work at all, and 57 percent were working for pay when interviewed. Comparable figures for nonrehabilitants were 19 percent, 60 percent, and 24 percent, respectively. Over a 36-month period following closure, the percentage employed for pay at the time of the interview decreased only slightly, to 55 percent. The amount of time worked for pay averaged just over 7 months per year, varying from about 6 months per year up to 9, depending on sex and race. The National Analysts study also presents new data on the percentage increase in earnings one, two, and three years after closure. In constant-value dollars, mean monthly earnings of rehabilitants up to 24 years old increased about 25 to 35 percent for males and 20 to 30 percent for females. For rehabilitants of all ages at the end of one, two, and three years, earnings increased 30, 32, and 32 percent, respectively, over the single base-year starting figure.

Because similar follow-up data on Nevada rehabilitants are not available, we must make assumptions as described above and test the sensitivity of the results of this analysis to those assumptions.

The total stream of benefits can now be estimated by multiplying the number of person-years of work life by the assumed increase in earnings due to the VR program for each type of handicapped client. Given a preference, however, one would prefer earnings this year to the same amount of earnings at some distant time in the future. To account for that preference, future benefits must be discounted. Just what is the proper amount to discount future costs and benefits from government projects has been subject to extensive study and controversy. Rather than choose a single discount rate, we will use 6 percent in our base-case analysis and examine some other values in the later section devoted to sensitivity analysis.

Societal Benefit/Cost Analysis: Base Case

For the base-case analysis of the relation of benefits and costs to society, we use Conley's methodology, modified as described above, and the data on Nevada mentally disabled VR clients derived from the FY 1974 case closures described earlier in this chapter. The next sections test the sensitivity of the analysis to various other assumptions, present our benefit/cost analysis using conservative assumptions intended to put the VR program to a hard test, and analyze the relation of benefits and costs to Nevadans and taxpayers.

The benefit/cost ratios to society using the base-case assumptions are presented

²⁸ Conley, "A Benefit-Cost Analysis," pp. 234-235.

²⁹ *A Follow-up Study of Closed Vocational Rehabilitation Cases, Final Report to the Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare, Contract No. SRS-69-54, April 1972.*

in Table 11.9. In all eight categories of mental disability, the economic benefits far outweigh the costs (the ratio is 1.0 if benefits equal costs). The lowest benefit/cost ratios are for psychotics, psychoneurotics, and people with some "other mental disorder"; in each of these cases, higher costs, rather than lower benefits, account for most of the difference in benefit/cost ratios for these three groups relative to other disability categories. The highest ratio is for people with an alcohol problem, and comes primarily from the higher earnings for these rehabilitants relative to those in other disability categories. Considered in terms of years of work time required to "break even," that is, to earn benefits to society equal to the costs incurred, the longest break-even years of work required will be for psychoneurotic clients since they have the lowest benefit/cost ratio. For psychoneurotic clients the average required work period to "break even" under the base-case assumptions is less than two years; for alcohol abusers the figure is less than six months (the shortest for any category of disability analyzed).

In summary, some types of mentally handicapped people do better than others in a benefit/cost sense, but the program appears to offer society a handsome return on investment for all eight categories of prevalent mental handicaps. This is in line with previous findings. As we vary some of Conley's assumptions, however, the success of the program appears to be somewhat less than the base-case analysis indicates. We now turn to sensitivity analysis.

Table 11.9

SOCIAL BENEFIT/COST RATIO OF NEVADA VR
FOR SELECTED TYPES OF MENTAL DISABILITY:
BASE-CASE ASSUMPTIONS

Type of Mental Disability	Benefit/Cost Ratio for Rehabilitant of Age:	
	20 Years	45 Years
Alcoholism	33	25
Drug addiction	21	15
MR, mild	18	13
MR, moderate	23	19
Psychosis	11	8
Psychoneurosis	8	6
Other mental disorder	11	9
Epilepsy	19	14
All types combined	14	10

Benefit/Cost Analysis: Sensitivity to Data and Assumptions

This section explores the sensitivity, to the above data and assumptions, of the conclusion that the VR program is highly cost-beneficial to society. Many combinations of data and assumptions are possible. Our tactic here is to vary the most significant of them one at a time so as to isolate and study their influence, and then to make what appears to be a realistic set of changes of more than one type of data and assumption.

Discount Rate. The base-case analysis used a discount rate of 6 percent. Its use assumes that government and private enterprise do not have investment opportunities that yield over 6 percent. While it is impossible to say what the correct discount rate is, since conditions in the future will change that rate, we can measure the effects of various discount rates on our conclusions. Any discount rate lower than 6 percent will raise the program benefits (the same future earnings are worth more in current dollars with a lower discount or interest rate), but leave the program cost for FY 1974 rehabilitants essentially unchanged. The opposite is true for higher discount rates, and so we must recalculate the ratios with a higher discount rate to see if the VR program still appears cost-beneficial to society. Table 11.10 shows the recalculated ratios assuming a discount rate of 10 percent; even with that change, the program still returns positive benefits relative to its cost for all eight categories of mentally handicapped clients studied.

Table 11.10

**SOCIAL BENEFIT/COST RATIO OF NEVADA VR
FOR SELECTED TYPES OF MENTAL DISABILITY:
BASE CASE WITH 10-PERCENT
DISCOUNT RATE**

Type of Mental Disability	Benefit/Cost Ratio for Rehabilitant of Age:	
	20 Years	45 Years
Alcoholism	22	19
Drug addiction	14	12
MR, mild	12	10
MR, moderate	16	14
Psychosis	7	6
Psychoneurosis	5	5
Other mental disorder	8	7
Epilepsy	13	11
All types combined	9	8

Cost. Several of the data and assumptions about cost can be debated. However, for any reasonable changes in the cost used, the conclusion that the program is cost-beneficial does not change. If the cost goes down, the benefit/cost ratio goes up. On the other hand, if the cost goes up by, say, 25 percent, while the benefits remain the same, the benefit/cost ratios decline by only 20 percent and are still high.

Number of Rehabilitants Who Continue to Work. The base-case analysis assumes a high mortality rate and still shows the program to be cost-beneficial. We will not use a still higher mortality rate because it appears unreasonably high already. The base-case analysis also assumes that 80 percent of those with earnings at closure have earnings five years from closure, and that later increases in earnings offset later increases in unemployment. If no change is made in the assumptions about the earnings of those who remain employed, total benefits decline as the 80-percent employment figure or the 5-year figure are lowered; the benefit/cost ratios in Table 11.11 are obtained for various assumptions about the percentage that stays in the labor force after two years. As the table indicates, the benefits exceed

Table 11.11

SOCIAL BENEFIT/COST RATIO OF NEVADA VR FOR SELECTED TYPES
OF MENTAL DISABILITY: SENSITIVITY TO RATE OF EMPLOYMENT

Type of Mental Disability	Benefit/Cost Ratio with Employment Rate After 2 Years of:					
	80%		50%		20%	
	Age 20	Age 45	Age 20	Age 45	Age 20	Age 45
Alcoholism	32	24	22	17	11	9
Drug addiction	20	14	14	10	7	6
MR, mild	17	12	12	9	6	5
MR, moderate	22	18	15	13	8	7
Psychosis	11	8	7	5	4	3
Psychoneurosis	8	6	5	4	3	2
Other mental disorder	11	9	7	6	4	3
Epilepsy	18	13	12	9	6	5
All types combined	13	9	9	7	5	4

the cost (ratio exceeds 1.0) for all categories of mentally handicapped clients, even if only 20 percent retain full-time employment after two years. Since no follow-up study on rehabilitants we are aware of has concluded that the rate of employment after successful rehabilitation is that low, the VR program for the eight categories of mentally handicapped persons appears to be cost-beneficial for all reasonable values of employment rate, if all other assumptions remain unchanged.

Earnings Gain Due to VR Services. A major assumption in the base-case analysis is that the earnings gain due to VR services is equal to the difference between reported earnings at time of referral and at closure. However, the assumption that earnings at referral are a good indication of what the client would continue to earn in the absence of the VR program is open to serious question. It is difficult to get an accurate estimate of what would happen to those clients if the VR program did not exist, since accurate data on earnings of mentally handicapped persons in the general population do not exist and because the VR program clients probably are not typical of that population.

Rather than trying to get a more accurate estimate of earnings without VR services, we use several different earnings assumptions to get an idea of their effects on the base-case analysis benefits. Table 11.12 shows the benefit/cost ratio of the VR program under three different assumptions about earnings without services. It is assumed that 25, 50, and 75 percent of those cases closed as successes would have been employed, with the average earnings equal to a 1974 minimum wage, in the absence of VR services (i.e., \$80 a week on the average).

According to the table, even if 75 percent of the rehabilitants could obtain minimum wage jobs on the average without VR services, the program would be cost-beneficial for the combined client population of all mentally disabled people, but would not be cost-beneficial in solely economic terms for mentally retarded people. (Where the benefit/cost ratio shown is negative, the VR program is less effective in earning terms than a program that puts 75 percent of the rehabilitants in minimum-wage jobs.) Within all the eight prevalent categories from the more severely to the

Table 11.12

**SOCIAL BENEFIT/COST RATIO OF NEVADA VR FOR SELECTED TYPES
OF MENTAL DISABILITY: SENSITIVITY TO ASSUMPTIONS ABOUT
EARNINGS WITHOUT VR SERVICES**

Type of Mental Disability	Benefit/Cost Ratio with Indicated Percentage Employed Without VR Services					
	25%		50%		75%	
	Age 20	Age 45	Age 20	Age 45	Age 20	Age 45
Alcoholism	27	21	22	16	16	12
Drug addiction	16	12	11	9	7	5
MR, mild	11	8	5	4	-1.4	-1.1
MR, moderate	16	12	8	6	0.8	0.6
Psychosis	8	6	5	4	3	2
Psychoneurosis	6	4	4	3	1.4	1.1
Other mental disorder	9	7	6	5	4	2
Epilepsy	14	11	10	7	5	4
All types combined	10	8	7	6	4	3

less severely disabled, including the mentally retarded clients, the VR program has economic benefits that exceed its costs even if about two-thirds or less earn the minimum wage in the absence of the program.

The practice of "creaming" and serving the least handicapped clients, if engaged in, would not necessarily lead to the largest economic return under the base-case analysis assumptions. This calls into question whether emphasizing service to less handicapped clients is in fact a rational, to say nothing about equitable, policy from the standpoint of economic return.

Societal Benefit/Cost Analysis: Conservative Assumptions Case

In the preceding section, several assumptions in the base-case analysis were varied individually, and the conclusion that the program is cost-beneficial in an economic sense did not change. In this section, we change three of the most significant base-case assumptions and recalculate the benefit/cost ratios for this new set of data and assumptions. The new assumptions are considerably more conservative than the base-case assumptions, and should present the VR program in the worst light that seems reasonable. If the VR program still appears economically cost-beneficial, we will conclude that the program is effective in a total social cost-benefit sense.

In calculating the benefit/cost ratios shown in Table 11.13, we assume the following:

- The discount rate is 10 percent.
- Only 50 percent of the mentally disabled rehabilitants are employed 2 years after closure.
- In the absence of the VR program, 50 percent of both the retarded and the psychotic rehabilitants, and 75 percent of the less severely handicapped rehabilitants, could have been employed and would have earned the minimum wage on the average.

Table 11.13

SOCIAL BENEFIT/COST RATIO OF NEVADA VR
FOR SELECTED TYPES OF MENTAL DISABILITY:
CONSERVATIVE ASSUMPTIONS CASE

Type of Mental Disability	Benefit/Cost Ratio for Rehabilitant of Age:	
	20 Years	45 Years
Alcoholism	8	6
Drug addiction	3	3
MR, mild	2	2
MR, moderate	4	3
Psychosis	3	2
Psychoneurosis	0.6	0.6
Other mental disorder	1.7	1.5
Epilepsy	3	2
All types combined	2.1	1.9

We emphasize that the true values of the above figures are not known, nor are they our best estimates. They are conservative estimates made to put the VR program to a hard test. Rather than assume, as in the base-case analysis, that without the VR program nearly all of these rehabilitants would be unemployed throughout their lives, we assume that a majority would be employed. And rather than assume a 20-percent unemployment rate for successful rehabilitants after five years, we assume a 50-percent unemployment rate after two years.

Under these much less favorable assumptions, the program still appears to have economic benefits that exceed its costs to society for each category of mentally handicapped client analyzed with the exception of psychoneurotic rehabilitants. This is true for even the severely handicapped groups analyzed, which some people might argue are "too expensive" to serve.

Many questions about the proper allocation of resources among handicaps cannot be answered with this type of analysis. However, the positive quality-of-life benefits of the program, coupled with favorable average economic benefits in relation to cost, imply that expansion of the VR program *could* have very desirable effects. If the program is to be expanded, however, it should be carefully and periodically reevaluated, because diminishing returns on investment can be anticipated as a larger fraction of the mentally handicapped population is served, and because our calculations have been of average costs and benefits, not the marginal costs and benefits of program expansion, for which data are not available. The above analysis also has not considered the distributional effects of the program in transferring dollars from one segment of population to another; the implicit assumption above is that the marginal value of the last dollar paid by the taxpayer equals the marginal value of a dollar to the recipient of service. Next, we consider costs and benefits from the viewpoint of the taxpayer who funds the service.

Benefits and Costs to Taxpayers

The previous analysis examined the VR program from the standpoint of society

as a whole. It did not consider the question of exactly who received the benefits and who paid the costs within society. In this section we view the VR program from the perspective of an investment decision for the taxpaying segment of society.

The costs borne and benefits captured by the taxpayer are different from those discussed in the previous sections. On the cost side, income maintenance payments during rehabilitation are a real cost to the taxpayer while the opportunity cost of withdrawing the client from the labor force is not. On the benefit side, only the increment in taxes paid by the employed rehabilitant, rather than the total increase in income, is counted as a benefit to the taxpayer. An additional benefit is the reduction in future welfare payments that is attributable to the VR program. The costs can be calculated from information presented previously.

To estimate the increase in taxes paid by mentally disabled rehabilitants, it is necessary to consider their income distribution presented earlier. The estimated federal income tax was calculated assuming the average taxpayer has one dependent other than herself or himself. (This will introduce a small downward bias in the benefits because the actual average was 0.7.) The Nevada sales tax payments were calculated from the federal "1974 Optional State Sales Tax Tables."³⁰ Future tax payments and welfare reductions were discounted at 10 percent. We also conservatively assume (to put the program to a hard test) that only 50 percent of the mentally disabled rehabilitants are employed two years after VR case closure.

We also face the problem of estimating taxes paid in the absence of the VR program. If we use earnings at acceptance as the tax base, the taxes paid will be negligible. We conservatively assume that in the absence of the VR program, 50 percent of the retarded and psychotic rehabilitants, and 75 percent of the less severely mentally disabled rehabilitants could have been employed, earning the minimum wage on the average. Again, we emphasize that the above assumptions are not our best estimates of the unknown true values, but are conservative estimates designed to put the VR program to a hard test by making low benefit estimates.

By placing clients in jobs, the VR program also reduces the number of mentally handicapped persons who need to rely on public welfare, and the program thus benefits the general taxpayer population. We estimate this reduction using welfare payments at acceptance and at closure as a measure of the decline in the amount of average welfare payments per client in the first year after closure. We also conservatively assume that only half the clients who are removed from public welfare rolls because of vocational rehabilitation will remain off those rolls for two years (this parallels our assumption that 50 percent will be employed at the end of two years following closure). An earlier section presented data on VR clients on public assistance and the amount of public assistance payments.

The benefit/cost ratios for the general taxpayer population are 1.18 for the average mentally disabled rehabilitant of age 20, and 1.03 for a rehabilitant of age 45, and the economic benefits exceed the costs to the taxpaying population even under the "worst case" conservative assumptions we have made.

Because we have excluded all property tax benefits, with a resultant underestimate of overall benefits, the program appears cost-beneficial as a taxpayer "invest-

³⁰ 1974 Federal Income Tax Forms, Form 1040, instruction booklet prepared by the U.S. Department of the Treasury, Internal Revenue Service, 1974, p. 22.

ment," just as it was shown to be cost-beneficial from the viewpoint of society as a whole and is cost-beneficial from the viewpoint of the individual VR client.

PRIVATE COMMUNITY VOCATIONAL CENTERS

Several private centers operate with partial government funding in a "Community Training Center" program under the auspices of the Nevada Division of Mental Hygiene and Mental Retardation (see Chap. 7 for details). Those private centers provide a variety of services, primarily for developmentally disabled preschoolers and adults, e.g., day care activities, developmental training, individual and family counseling, supervised living, work evaluation, prevocational and vocational training, and sheltered work. Vocationally related services are described in the following subsections on the centers that provide those services; other services by the centers are described in this report's chapters on education and training, and residential living. These centers are intended to provide services not available in any other program. The state-provided funding is a minimum of \$300 per enrollee per quarter year, with the actual amount depending on availability of funds. Each center receives a minimum of \$14,000 per year, providing staff expenses are equal to that amount and the center has a minimum of five certified enrollees per quarter. The state has paid a maximum of \$350 per enrollee per quarter in large centers and a maximum of \$15,000 per annum in small centers. In addition to the Centers described below, a new satellite Center recently opened in Gerlach-Empire and serves eight preschoolers and one adult.³¹

Elko Developmental School

The Elko Developmental School is primarily a preschool for developmentally disabled children, but a small sheltered workshop for adults is also in operation. The workshop does not do work evaluation.³² About 11 persons of all ages are served,³³ and some funds are received from the Community Training Center program.

Mineral County Sheltered Workshop

The Mineral County Sheltered Workshop serves about 13 people in Hawthorne.³⁴ It is primarily a preschool but also has a prevocational and vocational training program for developmentally disabled people.³⁵ The program is directed by a special education teacher, assisted by two half-time teaching aides plus volunteers. The adolescents' program includes supplemental activities for academic development, prevocational and vocational skills, recreation skills, socialization, and the refine-

³¹ "Mental Retardation Services in Nevada," Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, June 1973, and a letter from J. Middleton, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, to J. S. Kakalik, The Rand Corporation, Santa Monica, California, February 10, 1976.

³² Interview with M. Carroll, Community Training Center Coordinator, Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, October 7, 1974.

³³ "Rehabilitation Facility Plan," Nevada Rehabilitation Division, Carson City, Nevada, January 1, 1975.

³⁴ Ibid.

³⁵ Interview with M. Carroll.

ment of self-help skills. For the adult population, activities are conducted for daily living skills, prevocational and vocational training, socialization, and appropriate use of leisure time.³⁶

Opportunity Village Association for Retarded Citizens (OVARC)

In addition to functioning as an Association for Retarded Citizens, Opportunity Village provides a wide variety of direct services to retarded people in the Las Vegas area. It originated in 1954 as a parents' group; lessened a gap in services by operating a school for severely retarded children not served by the public schools until recently; again alleviated a gap in the public service system in 1968 when it opened the first sheltered workshop in the Las Vegas area with an associated large thrift store; and, most recently, moved to alleviate a shortage of appropriate residential living facilities for retarded adults by establishing residential apartments in 1971.³⁷ It closed the school it operated when the public schools expanded their service to include the group that Opportunity Village had been serving.

The Opportunity Village sheltered apartments are described in the chapter of this report on residential living facilities; the remainder of this subsection describes the vocational and other services provided.

Opportunity Village runs sheltered workshops at two locations in Las Vegas. In July 1974 a total of about 110 retarded adults (plus a very few people who were not retarded) worked in the two sheltered workshops.³⁸ The types of work involve operation of the large thrift store, an "activity" group to develop pre-employment skills, making and selling the products of arts and crafts, making buttons and signs, printing, and a wide assortment of work on contract from other organizations. Counseling is provided to every person involved in the workshop program, to some of their families, and to other retarded Clark County residents who desire it. Staff conferences are held for each trainee in each of his or her first three months in the program, and typically every three months thereafter. Each receives a hot lunch at 50 cents per day, or free if the trainee is unable to pay. Two OVARC buses and two vans provide transportation for the 60 percent of the trainees who need it. A \$1 a day charge is made for transportation, but more than half of those transported are unable to pay and hence are not required to. OVARC regards transportation as a vital part of their outreach to clients. Since public transportation is said to be inadequate, OVARC staff believe that if they did not transport people, they would be serving primarily two-car families and those who lived near enough to walk to the facilities.

The purpose of the workshop program is

... to provide work adjustment and work training experience for the mentally retarded and other handicapped individuals. The workshop program is designed for handicapped adults who are not presently employable, and who need a program that will allow them to develop under supervision into employable, productive human beings. The workshop program is also seen as a long-range activity for those individuals who may not be able to be

³⁶ "Description of Community Training Center Program," submitted by Mineral County Sheltered Workshop to the Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, 1974.

³⁷ "Board and Staff Manual," OVARC.

³⁸ Interview with Dr. Theodore Johnson, Executive Director, OVARC, Las Vegas, Nevada, July 17, 1974.

brought to the level of employability. Each handicapped person involved in the program is called a "trainee" with hope always present for progress toward employability. For those who must have a continuing long-range training program, it is intended that the workshop will provide partial employment.³⁹

The eligibility requirements are that the handicapped person be an adult who is no longer in school, and for whom no other appropriate vocational service program exists. The program operates eight hours a day, five days a week, at a cost of over \$250/month/trainee. Parents are asked but not required to contribute to the financial support of the program, and no individual is excluded because of inability to pay.

Workshop trainees are paid 10 cents to \$1 per hour depending on their competence, with some workers paid on a piece-rate basis receiving more.⁴⁰ Wages for piece-rate work are based on a \$2 per hour wage that would be paid to a normally functioning person. A time study is conducted on each work task in order to assign a wage for the piece rate. Thus, a client who performs at one-half the pace of a normally functioning person receives \$1 per hour. A worker who achieves about 70-percent productivity, however, is moved into competitive employment rather than being allowed to remain within the sheltered work environment.

The workshop atmosphere is pleasant, and the trainees we talked to seemed reasonably happy. The workshop seems to be functioning very well.

The workshop's clientele being drawn from the more severely handicapped population, it sometimes takes a long time to develop their vocational abilities. In fact, Opportunity Village has accepted clients that the VR program could not succeed with or would not accept. Opportunity Village maintains liaison with VR, however, and if people applying for service at OV have not been to the Nevada Bureau of Vocational Rehabilitation, they are sent there first. Numerous referrals of OVARC clients to other agencies providing complementary needed services are made. OVARC receives numerous referrals from VR, as well as from other service agencies.⁴¹

Opportunity Village does not have a waiting list for service. Instead, they attempt to expand to meet the need. However, the July 1974 OVARC staff of 38 had been expanded too fast, according to Dr. Johnson, then the Executive Director. He indicated that the staff had expanded rapidly because of the great need for services, but he candidly admitted this had made OVARC "much too thin on qualified staff."⁴² For example, the contract portion of the workshop had about 25 clients working in July 1974, with a staff of six, two of whom were college graduates but none of whom had professional vocational service training. That staff performed a quality control function, trained workers, and did some work testing and evaluation. However, Opportunity Village is far from unique in being "thin" on professional personnel, and is providing greatly needed services. Elsewhere in this report we note other programs in Nevada with a similar personnel problem.

The 1974 OVARC budget was just under half a million dollars, with the thrift store providing about half of the income. Only about 22 percent of the income came from government sources, and only 16 percent came from United Way and other

³⁹ "Board and Staff Manual," OVARC.

⁴⁰ Interview with Dr. Johnson.

⁴¹ Ibid.

⁴² Ibid.

contributions. Government sources providing income were primarily the VR program (Nevada Division of Rehabilitation) and the Community Training Center program (Nevada Division of Mental Hygiene and Mental Retardation). Over 60 percent of the expenditures were for salaries and related expenses (see Table 11.14). In addition to the above budget, the Bureau of Vocational Rehabilitation has recently awarded Opportunity Village a work evaluation equipment grant (shown in the VR budget earlier in this chapter).

Table 11.14

**BUDGET OF OPPORTUNITY VILLAGE ASSOCIATION
FOR RETARDED CITIZENS, 1974**

Support		
Contributions		\$ 25,000
Special events		30,138
Government income		100,000
Membership		1,000
Fees		33,000
Sales		225,000
United Way		48,212
Total, support		<u>\$462,350</u>
Expenditures		
Salaries		
Professional	\$ 89,397	
Clerical	29,687	
Trainee	18,000	
Other	<u>119,166</u>	
Total salaries		256,250
Health and retirement, payroll taxes, etc.		32,500
Outside services		4,800
Supplies		26,000
Telephone, postage		6,700
Occupancy		89,000
Outside printing		4,000
Transportation		15,000
Conferences, publications, awards		5,700
Equipment		3,000
Cost of resale items		10,000
Organization dues, national support		<u>9,400</u>
Total expenditures		<u>\$462,350</u>

SOURCE: OVARC, "Board and Staff Manual," 1974.

Ormsby Association for Retarded Citizens

The direct service programs offered by the Ormsby ARC include one for pre-school, one for school-age, and one for adult work adjustment and vocational training. The primary focus of this ARC is on the two programs for children which are discussed in the education chapter of this report. Developmentally disabled people from Carson City, Lyon County, and Douglas County are served by the Ormsby ARC, which sees itself in a "residual role in the community by offering services to all

developmentally disabled citizens not served by public school special education programs because of age, type or severity of handicap, or behavioral problems."⁴³

A total of eight adults were receiving vocational services in November 1974. According to the Program Director, the ARC does not operate a sheltered workshop but rather a work adjustment and work activities program. Adults are given training in daily living skills and work adjustment (e.g., group cooperation, work habits, self-control). Work activity consists of providing janitorial service at the ARC Center and some assistance at a small thrift store in Carson City. In the last half of 1974, one adult was placed in a job (as a half-time shipping clerk), and two more were thought to be placeable in competitive employment after additional training.⁴⁴

The current Ormsby ARC programs are in facilities not well suited to a vocational program, and are overcrowded. Near-term future facility plans include acquiring a larger thrift store with room for a workshop area, and a large mobile home so that they can accept contract work they do not have room for now.⁴⁵

Detailed budget data were not available for FY 1974. Funds come from eight sources, several of which are not stable long-term sources. The majority of funds are from government sources. In addition to VR and Community Training Center fees from the state, a total of \$88,000 in other government grants was received in FY 1974. Three VR grants were used to buy equipment and to pay for a workshop/transportation coordinator, a psychologist, a speech therapist, and a secretary. A Developmental Disabilities program grant was used to pay for a "community service" person. The remainder of the funds came primarily from the thrift store (\$19,000 in the first nine months of 1974), and also from tuition (based on ability to pay), contributions, and ARC membership dues.

The total ARC budget projected for FY 1975 was expected to be approximately \$125,000, with less than half of that going for vocational services (8 adults out of 20 clients in November 1974). The ARC staff for all three program areas numbers 18 and includes one rehabilitation counselor, a half-time psychologist, a social worker, a half-time speech therapist, a part-time physical therapist, two teachers, one teacher's aide, and six "foster grandparents."⁴⁶

Panaca Community Training Center

Panaca is in Lincoln County not far from the Utah border. The Panaca program operates in a room in the local community center, and serves approximately 13 people.⁴⁷ The center provides a variety of types of training for retarded persons not served by any other existing program. Clients are evaluated by a psychologist, a nurse, and a special education teacher. The regular staff of three conduct daily living and prevocational training (e.g., in coordination, speech, motor skills, food preparation, social skills). Some physical therapy is provided and transportation is provided

⁴³ "Description of Community Training Program," filed by Ormsby ARC, Carson City, Nevada, with the Nevada Division of Mental Hygiene and Mental Retardation, 1974.

⁴⁴ Interview with S. Landis, Ormsby ARC, Carson City, Nevada, November 15, 1974.

⁴⁵ Ibid.

⁴⁶ Ibid.

⁴⁷ Nevada Rehabilitation Division, "Rehabilitation Facility Plan."

to clients if needed.⁴⁸ Only one preschool-age person is served, and an attempt is being made to have that child served in the more appropriate school setting.⁴⁹

Washoe Association for Retarded Citizens

The Washoe ARC serves people primarily in the Reno-Sparks area (Washoe County) but also aids residents from other counties that lack a local ARC, when it is feasible to do so. The association performs a major advisory and advocacy function. Members provide representation to at least 20 major organizations and committees, such as the Governor's advisory boards on developmental disabilities and rehabilitation. They have actively supported a lawsuit demanding equal education for handicapped children as well as various pieces of legislation to improve services to handicapped people. The Washoe ARC operates a major and diverse direct service program, including work evaluation, counseling, work adjustment, a workshop, and an associated thrift store. It also operates an educational-residential facility for retarded adults; it is discussed in this report's chapter on residential living.

The Washoe ARC first began providing direct services in 1966 and has grown rapidly since then. The original service focus was on a Child Development Center for mentally retarded children; it was phased out in 1973 when the local school district assumed the responsibility for serving those children. The residential facility program began operation in 1974, at which time the vocational service program also was significantly expanded with state-federal funding. Like the Opportunity Village program, the Washoe ARC services were first initiated to help fill gaps in publicly provided services, and are modified in response to improvements in the public programs.

The Washoe ARC evaluation program, started in October 1974, assesses each client's handicap and vocational service needs. The diagnostic evaluation, which lasts up to eight weeks for each client, includes pertinent medical, psychological, vocational, educational, social, and other factors. Work behavior, attitudes, habits, work tolerance, and ability to acquire new occupational skills are assessed in real work test situations and by other means. Following evaluation, the client may proceed to competitive employment, work adjustment training, or a sheltered workshop, and may receive a combination of other needed services. Some (expected to be a very small percentage) will be determined to have "no vocational potential."⁵⁰

The State Bureau of Vocational Rehabilitation also operates a work evaluation and work adjustment training center in Reno. However, the intent is for the VR program to send all mentally retarded people to the Washoe ARC program for evaluation in a cooperative arrangement rather than operating duplicate evaluation programs. The VR program is providing one full-time vocational counselor and one full-time secretary to work with the Washoe ARC program.⁵¹

The Washoe ARC evaluation program will admit four people per week (and thus will expect to complete service for about 200 people per year), resulting in a signifi-

⁴⁸ "Description of Community Training Center Program," submitted by the Pzena Community Training Center to the Nevada Division of Mental Hygiene and Mental Retardation, 1974.

⁴⁹ Interview with M. Carroll.

⁵⁰ Interview with L. Hoover, Washoe ARC, Reno, Nevada, September 19, 1974, and a letter from M. Wedge, Washoe ARC, Reno, Nevada, to J. S. Kakalik, The Rand Corporation, Santa Monica, California, March 1976.

⁵¹ Ibid.

cant increase in the number of developmentally disabled people receiving vocational services in northern Nevada. All will be clients of the state VR Bureau. Expenses for the first year of the evaluation program are being paid by a grant from the state VR Bureau, and will probably be paid by direct charges to the VR Bureau for each client served in subsequent years. Prior to admission to the Washoe ARC evaluation program, potential clients will be given a medical and psychological screening by the VR program.³³

The Work Adjustment (and prevocational training) program emphasizes the retarded person's work attitudes, plus provision of other services such as speech or physical therapy, counseling of the retarded person and his or her family, and adult educational services if shown to be needed in the prior evaluation. Prevocational training may include, if needed, skills in using public transportation, use of money, reporting for work on time, and so forth. This program will include about two hours per day in a classroom setting (or the community as a classroom) and the remainder of the day in the workshop.³⁴

The two thrift stores operated by the Washoe ARC receive donated articles for sale, process and sell those articles as part of the sheltered workshop program, and provide funds needed for provision of services.

The sheltered workshop for retarded adults from age 16 includes a work activities program and a regular sheltered work program, both certificated by the U.S. Department of Labor. (These were the only certificated vocational facilities in Nevada in mid-1974. Accreditation is also being sought for the newly initiated Evaluation and Work Adjustment programs at Washoe ARC.) Emphasis is not solely on vocational concerns, but also on social daily living skills that enable people to function in society. The workshop employs about 40 adults (age 16 years and up) who cannot now and may never be able to hold a competitive job. The workshop also includes diverse jobs resulting from contract work for other organizations (e.g., printing, making signs and buttons), a printing skills training program within the workshop, and a skill training program for maid service that has been arranged with a local hotel. Participants in the work activities program earn 10 cents to 10 cents per hour. All regular sheltered workers in the workshop are paid one-half the federal minimum wage or higher.³⁵

Fees of \$0 to \$150 per month are charged to the families of the developmentally disabled clients in the workshop, depending on ability to pay. For example, a family with two children and an income of \$15,000 per year would be requested to pay \$50 per month.³⁶

Following evaluation, work adjustment, and work training, clients adjudged capable of competitive employment receive job placement service, primarily from the Bureau of VR liaison counselor (with assistance from the Washoe ARC staff).³⁷

The total Washoe ARC staff numbered about 22 in 1974. Professional staff members number about nine; they include vocational specialists, one psychologist, two social workers, and two teachers. About seven "foster grandparents" work half-time at Washoe ARC and were said to make a valuable contribution to the

³³ Ibid.

³⁴ Ibid.

³⁵ Interview with M. Wedge, Washoe ARC, Reno, Nevada, May 10, 1974.

³⁶ "Weekly Fee Schedule," Washoe ARC, Reno, Nevada, 1974 (mimeograph).

³⁷ Interview with M. Wedge.

program, although they were alleged to be overly permissive in the behavior they will tolerate from clients. The staff members each spend one day per month for in-service training.

The 1974 Washoe ARC budget of about \$347,000 is described in Table 11.15. In addition, but not listed in the table, the Washoe ARC has received a multiyear Developmental Disability grant totaling over \$200,000 to pay for education of developmentally disabled adults, and a \$90,000 VR program grant to help provide for equipment and remodeling for start-up of the evaluation program. Funds for the new Washoe ARC residential center are also not shown.⁶⁷

Table 11.15

PRINCIPAL BUDGET OF WASHOE ASSOCIATION FOR
RETARDED CITIZENS, 1974

Support	
Contributions	\$ 6,800
Special events	45,000
Government income	109,160
Membership	700
Fees	26,500
Sales	63,350
United Way	15,000
Other	11,300
Total	\$337,810
Expenditures	
Salaries	
Staff	\$153,522
Trainees	28,800
Health and retirement, payroll taxes, etc.	25,317
Outside services (professional and contract)	700
Supplies	11,875
Telephone, postage	5,310
Occupancy	39,107
Institutes and workshops	2,280
Equipment	18,900
Special events	28,000
Organization dues, national support	5,000
Miscellaneous expenses	28,115
Total	\$346,989

SOURCE: Letter from M. Wedge, Washoe ARC, Reno, Nevada, March 1976.

The Washoe ARC would like to be more financially independent than it is now, and plans to seek financial support of approximately \$2 million to start self-supporting businesses that can provide both work and training for developmentally disabled people. One concept presented to us was a motel-restaurant-casino complex with no architectural barriers and emphasizing but not limiting service to handicapped people. Advertising would be national and the unique feature would be the combina-

⁶⁷ Interview with L. Hoover, Washoe ARC, Reno, Nevada, September 19, 1974, and a letter from M. Wedge, Washoe ARC, Reno, Nevada, to J. S. Kekalik, The Rand Corporation, Santa Monica, California, March 1976.

tion of the casino and emphasis on serving handicapped people. The businesses would not only serve handicapped and nonhandicapped guests but also provide training and work for developmentally disabled people, and profits that could support other Washoe ARC program activities.⁸⁸ The concept is interesting and potentially very beneficial, but its economic viability is uncertain. Employment and training for developmentally disabled people can be achieved at lower current costs and lower risks without funding such an extensive facility, but perhaps with lower potential financial rewards. Given the limited funds currently available to expand services and better meet the needs of the mentally handicapped population, it becomes a matter of priorities.

The Washoe ARC programs in general are professionally staffed and appear to be providing good services. The Washoe ARC strives to meet nationally recognized accreditation standards. The programs are currently in a stage of rapid expansion and, judging from our discussions with families of participants, are generally satisfying the people they serve. Many of the ten families we interviewed as a group agreed with one family's statement that the Washoe ARC had done more to help their child be independent than had all the other services received during the childhood years.⁸⁹ In fairness to other service agencies, we point out that the quantity and quality of nearly all types of services are much higher today than when these families' disabled children were young.

White Pine County Rehabilitation Center

The White Pine County Center is a daily living and prevocational skills training center for developmentally disabled adults, although in late 1974 one 14-year-old was attending. (The child was not attending public school, despite Nevada's new mandatory special education law, because of a conflict between the child's family and the school. According to the state Community Training Center Coordinator, there was no appropriate service program in Ely for that child.)⁹⁰ The one full-time and two part-time staff members, assisted by volunteers, train people in skills such as money handling, letter writing, cooking, cleaning, gardening, recreation, daily self-care, shopping.⁹¹ The approximately seven people in the program are served in the basement of a church.⁹²

VOCATIONAL TRAINING PROGRAM

The Vocational Training Program in 1974 provided vocational evaluation, training, and job placement to adolescent and adult mentally retarded people, primarily in northern Nevada.⁹³ The program could take people of any degree of

⁸⁸ Ibid.

⁸⁹ Interviews with families with developmentally disabled adults (interviewees were guaranteed anonymity), Washoe ARC, Reno, Nevada, August 21, 1974.

⁹⁰ Interview with M. Carroll.

⁹¹ "Description of Community Training Center Program," submitted by the White Pine County Rehabilitation Center to the Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, 1974.

⁹² Nevada Rehabilitation Division, "Rehabilitation Facility Plan."

⁹³ "Mental Retardation Services in Nevada," Nevada Division of Mental Hygiene and Mental Retardation, Reno, Nevada, June 1973.

retardation, but insisted that they have basic self-help skills. The goal of the program was placement in competitive employment and hence, while they could take clients from NMHI (where the program facilities are), they usually did not. According to the program's director, "institutional types are usually just evaluated."⁶⁴ The caseload of 10 people in November 1974 included six referred from the community, three from the Northern Nevada Mental Retardation Center, and one referred from NMHI. Twenty-eight people were evaluated in FY 1974; 14 were placed, 2 were trained but not placed, 9 were not accepted, and 3 were still in the program in November 1974.⁶⁵ A follow-up study of clients previously served by the vocational training program found that in the first three years of the program 44 clients were at least evaluated, slightly less than half were employed at the end of their service time, and about three-quarters of those employed at the end of service were still employed at the time of the program evaluation (i.e., had been employed for from a few days up to three years depending on when in the previous three years they had been served). The average wage was about \$1.75 per hour (about the same as moderately retarded VR rehabilitants earn at time of case closure).⁶⁶ Since 1974, there has been a shift toward providing pre-workshop services.

The program was begun in 1969 on a federal adult education grant with matching money from the Nevada Department of Education. Presently, the program is funded entirely with state money and operated by the Nevada Division of Mental Hygiene and Mental Retardation. The annual budget of \$36,000 includes \$5000 from the Department of Education to expand the program's services.⁶⁷

The staff includes a director (who has a bachelor's degree in sociology but no prior experience or training in the vocational area), two additional people at Sparks full time (a sociologist and a teacher), and one person in Las Vegas (no special training or experience in the vocational area). All clients of this program are also VR program clients. The Bureau of Vocational Rehabilitation provides a physical and psychological evaluation, plus medical rehabilitation if needed (for example, one man in the program in November 1974 who came from NMHI reportedly had not had an eye examination for 12 years and needed a pair of glasses).⁶⁸ The Vocational Training program staff then conduct an academic skills evaluation, independent living skills evaluation, and a vocational evaluation including various trial work tasks. Persons functioning at or close to competitive employment levels are then accepted. The VR program will then pay for some clients to go to a vocational adjustment center for prevocational training (usually the Washoe Association for Retarded Citizens' program), and will also pay for transportation during training.⁶⁹

The Vocational Training staff goes into the community to develop job placement, and then trains the client on the job. The training is one-to-one, with the average training time being two weeks full time, eight hours a day, followed by two weeks of gradually withdrawn supervision, and a final two weeks of minimal supervision. A typical program would involve one week of evaluation and six weeks of

⁶⁴ Interview with S. Malley, Vocational Training Program, 480 Galletti Way, Sparks, Nevada, November 15, 1974.

⁶⁵ *Ibid.*

⁶⁶ "1972-1973 Evaluation—Vocational Training Program," Nevada Division of Mental Hygiene and Mental Retardation, undated.

⁶⁷ Interview with S. Malley.

⁶⁸ *Ibid.*

⁶⁹ *Ibid.*

on-the-job training. The longest any person has been in the program is two years, and the shortest is one week, when a placement was made and the person did not require training in the job.⁷⁰

The major service distinctions between the VR program and this program are the higher professional vocational training and experience of the VR staff and the relatively expensive one-to-one training provided on-the-job by the Vocational Training program but not by the VR program. While one could argue that the vocational training work evaluations should be conducted by more vocationally skilled professionals, the current hard-working and dedicated staff members in this program probably have adequate skills to conduct the actual job training, given the semiskilled nature of the placements being made (e.g., laundry, kitchen, janitorial, maid, ranch, and warehousing jobs).

VOCATIONAL EDUCATION PROGRAMS

The Nevada Department of Education, through the provision of vocational education and special education funding to local and other state education programs, supports the provision of vocational-technical education to both handicapped and nonhandicapped Nevadans. Much of the vocational education funding is federal money (\$1,268,184 for FY 1974) channeled through the Nevada Department of Education and requiring 50:50 matching funds. The matching funds come partially from the state (the FY 1974 state vocational education budget was \$386,805 above the federal vocational education grants) and partially from local education sources (approximately \$950,000 was required from local sources to provide the balance of the 50:50 matching funds). Actual provision of the vocational education services is usually by the local education agency.⁷¹

While it was not feasible to determine the total vocational education expenditures for handicapped people, the federal *Vocational Education Act of 1963, as Amended*, provides that 10 percent of the vocational education funds expended must be spent on handicapped individuals. This would indicate FY 1974 vocational education expenditures for handicapped people should have been at least \$253,000.

Except in the remotest rural areas of the state, some vocational education services are provided to handicapped people. Three special education vocational counselors work in rural areas, two work in Washoe County (Reno area), and five work in Clark County (Las Vegas area).⁷² The following paragraphs describe vocational education programs in the two metropolitan counties and one illustrative rural county.

In Churchill County, four local education employees work in the vocational field for all nonhandicapped and handicapped students. Each of them has been given in-service training in helping handicapped children by staff members responsible for special education. Most of the mentally handicapped students served by vocational education staff are educable mentally retarded youth. Nothing is presently done for career development of trainable mentally retarded students, and the special education director believes this is an important need throughout the state. The vocational

⁷⁰ Ibid.

⁷¹ *The Executive Budget*.

⁷² Interview with L. Davis, Nevada Department of Education, Carson City, Nevada, August 19, 1974.

needs of handicapped students are also served by making every effort to get each handicapped adolescent accepted into the vocational rehabilitation program before completion of the high-school-age education program.⁷³

In the Las Vegas area during the FY 1974 school year, the special vocational education program for all handicapped students consisted of four vocational counselors for mentally retarded youth plus activities at the Stewart School (for trainable or severely and profoundly retarded children) and the Variety School (for multiply handicapped children). The district had about 1600 educationally and mentally handicapped students in FY 1974. The four vocational education counselors outside the two special schools generally work with vocational rehabilitation personnel and senior high school teachers of mentally retarded youth to provide job information and placement assistance. In addition, some vocational education funds are used to pay youth to work in the schools so that they can learn job skills. The regular vocational education program may also accept some handicapped students in classes such as graphic arts, auto repair, electrical-electronics, building trades, and practical nursing, and in industrial cooperative classes (study plus part-time work), but the number so accepted is not available.⁷⁴

The Variety School for the more severely multiply handicapped youth in Las Vegas has one vocational counselor who provides a half-day prevocational and vocational skills training program for older students, and does informal follow-up after a youth leaves school. Approximately 40 students work around the school as part of their vocational education. The school principal indicated that a major need is for improved vocational rehabilitation program services for severely handicapped youth. His view was that currently the VR program emphasizes evaluation and placement but provides little of the needed training and follow-up.⁷⁵

The basic objective of the Stewart School for trainable severely or profoundly retarded youth in Las Vegas is vocational, which the principal broadly defines as being able to work and function as independently as possible upon leaving school. Attempts are made to teach prevocational skills to all students, for example, how to use a bus, and how to behave while waiting for and riding on the bus, so that the person can get to a job. The school also operates a small farm for vocational and other training purposes (e.g., animal care, gardening, and lawn care are taught). To supplement the school farm training for some youth, a cooperative training program has been worked out with a local nursery. At age 17 all students at the school work half-time, generally at the school. Examples of jobs are culinary skills (lunch is prepared and served for all students, and a commercial dishwasher of the same type used by local restaurants is operated), garden and yard maintenance, custodial work, and car washing. They are taught to work independently, and spend one month at each of the various jobs. Some vocational education funds are used to pay student workers. Following graduation, most of the students are placed either in competitive jobs or in the Opportunity Village sheltered workshop. Unlike other schools in the state, this one has a full-time liaison counselor funded by the VR program.⁷⁶

⁷³ Interview with W. Hammer, Churchill County School District, Fallon, Nevada, November 21, 1974.

⁷⁴ Interview with D. Seigle, Clark County Department of Education, Las Vegas, Nevada, October 24, 1974.

⁷⁵ Interview with H. Marr, Variety School, Las Vegas, Nevada, October 25, 1974.

⁷⁶ Interview with Dr. R. Foster, Helen J. Stewart School, Las Vegas, Nevada, October 25, 1974.

The Community College in Las Vegas also has a vocational training program funded by a Developmental Disabilities program grant. The 14 adult students are served in both a regular community college class setting and a work setting. It is the only community college program in the state specifically for vocational education of handicapped students.⁷⁷

Note that vocational education programs for the mentally handicapped in the Clark County School District emphasize and focus on service to retarded children but not to people with other types of mental handicaps. Also, none of the vocational education services were provided to children in the large rural areas of the county outside of the Las Vegas-Henderson metropolitan area. Vocational counseling is emphasized, but vocational training generally is not. The transition in Clark County from vocational service while attending school to service for those who need it after leaving school is not well coordinated, and judging from the relatively small number of retarded clients on the VR rolls from Clark County, that transition is frequently not made.

In Washoe County (Reno area only), the high-school-age special education program is vocationally oriented. It includes exposure to various types of work through audiovisual tapes (made locally with vocational education funds), field trips, work at the school, and counseling and evaluation. Also part of the high school special education program is the opportunity to work half-time offcampus while studying half-time. In FY 1973 and FY 1974, approximately 125 handicapped youth worked half-time under the guidance of two vocational counselors who provided placement, some supervision, and some one-to-one counseling. A follow-up study indicated that 70 percent of these students retained their jobs after graduation. No cooperative arrangement exists between the Washoe County School District and the Vocational Rehabilitation program; VR counselors provide no service of any sort to handicapped students in this county. Other than the two vocational counselors mentioned above, there is no vocational education program staff for handicapped students in Washoe County. No vocational education services for handicapped students exist in rural Washoe County.⁷⁸

EMPLOYMENT SECURITY PROGRAM

The purpose of the Department of Employment Security (ES) is to "promote employment and the re-employment of unemployed workers in the state, insure through unemployment benefits income for a worker during periods of unemployment, and through efforts in both areas reduce taxes for the state employers."⁷⁹ The promotion of employment and re-employment is done primarily through job information and placement; the Department acts as a central clearinghouse where workers can learn of job opportunities, and potential employers can learn of workers' availability. In FY 1974, of the 79,073 new applications and referrals of individuals, about one-third were placed in jobs, only four percent were counseled, only about

⁷⁷ Ibid.

⁷⁸ Interview with R. Berry and G. Myers, Washoe County School District, Reno, Nevada, November 20, 1974.

⁷⁹ B. Artzell, "State Goals," Office of the Governor, Carson City, Nevada, March 1, 1974.

one percent were referred for training, and only about two percent were referred for other services.⁹⁰

This program is subject to dictates from the United States Department of Labor, Manpower Administration, which supplies the majority of the total operating funds. Total FY 1974 expenditures, exclusive of unemployment compensation payments, were approximately \$7,605,000.⁹¹

To place the Department's work in context, in calendar year 1974 the annual average number of workers covered by the Nevada Unemployment Compensation Law totaled 216,987 (see Table 11.16 for a breakdown by industry). The total 1974 payrolls for those workers was over \$2.0 billion. Clark County (56 percent of the state's population) accounted for 55 percent of the covered workers and 56 percent of the payroll, while Washoe County (25 percent of the state's population) accounted for 27 percent of the workers and 26 percent of the payroll.⁹²

Table 11.16

NEVADA WORKERS COVERED BY UNEMPLOYMENT COMPENSATION,
BY INDUSTRY, 1974

Federal Government	9,080
State and local government	594
Agricultural services	783
Mining	4,289
Construction	15,427
Manufacturing	12,127
Transportation, communications, utilities	14,948
Wholesale and retail trade	49,899
Finance, insurance, real estate	10,678
Service industries	99,094
Other	118
Total	216,987

Table 11.17 presents data on the number of mentally handicapped people served in FY 1974 by (ES). Only 337 out of 79,073 new applications and referrals in FY 1974 were reported to have mental handicaps, and most of those people were thought to be retarded. No definitive breakdown or definition by type of mental handicap was available, since the reporting form has only one box for ES personnel to check to indicate a mental handicap. Those ES personnel are not skilled mental disorder diagnosticians, and may be hesitant to label a person as mentally handicapped when it serves no useful purpose to do so: The federal funding level depends on the presence of handicaps, but is independent of the types of handicap. Of the 337 reported mentally handicapped clients in FY 1974, 66 were counseled, 82 were

⁹⁰ Unpublished data provided by Frank Coleman, Nevada Employment Security Department, Carson City, Nevada, November 20, 1974, and by Lawrence McCracken, Nevada Employment Security Department, Carson City, Nevada, February 27, 1976.

⁹¹ *The Executive Budget*.

⁹² *Employment and Payrolls, Nevada, 1974*, Nevada Employment Security Department, Carson City, Nevada, undated.

Table 11.17

**NEVADA EMPLOYMENT SECURITY DEPARTMENT SERVICE TO
MENTALLY HANDICAPPED PERSONS, FY 1974**

Service	Mentally Handicapped
New applications and referrals	337
Counseling	66
Job Placement	82
Enrolled in training	8
Referrals to training	84
Referred to supportive services (including VR)	30

SOURCE: Unpublished data provided by L. McCracken, Nevada Employment Security Department, Carson City, Nevada, February 27, 1976.

placed in jobs, 8 were enrolled in training, 84 were referred for training, and 30 were referred for supportive services, including vocational rehabilitation. In response to questioning about the low number of mentally handicapped people served, department personnel estimated that less than half of those with mental handicaps who are served are identified as such, and that those who were not identified were probably higher-functioning people with higher placement rates. They also speculated that perhaps as many as 25 percent of the department's clients might have some mental problem.⁸³

ES has offices in Carson City, Elko, Ely, Fallon, Las Vegas, North Las Vegas, Lovelock, Reno, Sparks, Lake Tahoe, Winnemucca, and Henderson. ES has a few job developers who work with individuals and in employer relations; Reno has four job developers, Las Vegas has six, and Carson City, Elko, and Fallon each have one. However, most of the mentally handicapped people served are served by ES personnel without specialized knowledge of the vocational abilities of mentally handicapped people.⁸⁴

A problem with the Federal Government is that it is reportedly "consistently inconsistent" in changing priorities and setting up special programs, resulting in a great deal of uncertainty and change in both projects and budgets. The formula for payment from the Federal Government is based on such factors as duration of employment, handicapped people placed, veterans placed, and the percentage of clients who are placed. Thus, a person who is both placed and handicapped counts more in the formula than one who is only placed. Note that if the Employment Security Department could get credit for all vocational rehabilitation program closures, it could get more dollars from the Federal Government and provide better service.⁸⁵

⁸³ Interview with Lawrence McCracken, Executive Director, and Frank Coleman, Nevada Employment Security Department, Carson City, Nevada, November 19, 1974, and a letter from L. McCracken to J. S. Kakalik, The Rand Corporation, Santa Monica, California, February 27, 1976.

⁸⁴ Ibid.

⁸⁵ Interview with Lawrence McCracken.

A special problem for handicapped clients is that there is a tendency for ES employees to give lower priority to people they think will have a harder time getting jobs.⁶⁶

NEEDED IMPROVEMENTS IN VOCATIONAL SERVICES

Need for Vocational Services

To estimate the maximum potential number of mentally disabled Nevadans who need vocational rehabilitation services, the Nevada Rehabilitation Division conducted a household survey asking 1750 people over age 12 to self-report their perceived activity limitations and past loss or denial of job, raise, or promotion due to a mental, nervous, or emotional condition. The Nevada Rehabilitation Facility Plan for 1975-1980⁶⁷ assumes that the percentage of the population saying that at some time they had lost or been denied a job, promotion, or raise because of a physical or mental condition constitutes the number of people potentially in need of vocational services.⁶⁸ Of course, not all those people are currently vocationally disabled, and only a small fraction of them need vocational rehabilitation services each year; consequently, the Rehabilitation Facility Plan's use of the maximum potential need sets a high and perhaps unrealistic upper bound on the need. A better estimate, in our view, can be obtained from the same survey data by considering the number of people with hampering mental conditions who are unemployed. Of the 1.9 percent of the Nevada survey respondents self-reporting activity limitations due to mental, nervous, or emotional conditions, 15 percent were adults who were recently or temporarily unemployed, 20 percent were retired, 24 percent worked as housewives, 34 percent were employed in other occupations, and 7 percent were not in any of those categories (hence, they may have been students or long-term unemployed).⁶⁹ The use of a 15-percent figure (the recently or temporarily unemployed) plus the number currently in sheltered work programs would probably be a conservative minimal estimate of the number of mentally disabled adults who currently need vocational services, since it does not include the underemployed (employed in occupations significantly below their potential abilities) or the long-term unemployed. Assuming that a minimum of 15 percent of the 16- to 64-year-old mentally disabled population with activity limitations need some vocational service each year, plus those in sheltered work programs, the estimate of need would be about 1230 adults in 1974 and about 1650 in 1985. Data from the survey do not permit categorizing the causes of the "mental, nervous, or emotional condition" into mental health problems, mental retardation, and substance abuse. For lack of better data, we have assumed that the breakdown of the 15 percent by type of mental condition is the same as for current vocational rehabilitation clients; this yields a 1974 esti-

⁶⁶ *Ibid.*

⁶⁷ "Rehabilitation Facility Plan, 1975-1980," Rehabilitation Division, Nevada Department of Human Resources, Carson City, Nevada, January 1, 1975.

⁶⁸ *Ibid.*, p. 101.

⁶⁹ Unpublished data obtained from J. Pollard, Nevada Rehabilitation Division, Carson City, Nevada, May 15, 1975. For comparison, the monthly 1974 unemployment rate for all Nevadans varied from about 7 to 10 percent according to Department of Employment Security figures.

mate of vocational service need for 180 adults with mental health problems, 350 with mental retardation, 260 with an alcohol or drug abuse problem, and 440 people with some other mental problem. To estimate the vocational service needs of mentally retarded youth, we assume that at least 2 percent of the young adult population is retarded (see Chap. 3), and that every retarded youth of school-leaving age needs at least some vocational service. That assumption results in a 1975 estimate of approximately 200 retarded youth annually reaching an age where they need vocational services. If they receive some vocational education services over a two-year period, 400 need some vocational service each year.

The same number of seriously emotionally disturbed youth potentially need some vocational services if, for lack of better data, one uses the U.S. Bureau of Education for the Handicapped estimate of the prevalence of that condition.⁸⁰

The 1975-1980 Nevada Rehabilitation Facility Plan attempts to place priorities on service needs for 1975-1980 by surveying Division of Rehabilitation counselors. Of the twelve needs ranked, psychological/psychiatric service needs were ranked number one.⁸¹

The relatively higher unemployment and underemployment rates among mentally handicapped people, as compared with the nonhandicapped, are thought to be due to such factors as employers' underestimation of the abilities of handicapped persons, employers' "fear of the unknown," and the relatively longer on-the-job training period that may be required for some. Although these handicapped persons' abilities to perform in certain occupations are impaired, there is an abundance of other occupations in which they can be as productive as persons without mental handicaps.⁸² While the data on the number of mentally handicapped people needing vocational services could be more reliable, we note that youth with mental health problems are presently getting virtually no special vocational education service, and the greatest proportion of those mentally handicapped people presently not accepted for VR services are rejected not for lack of a mental or vocational handicap but for other reasons. Thus, it is reasonable to assume that significantly more mentally handicapped people need vocational services than are presently receiving them.

Problems with Current Vocational Services in Nevada

While the vocational service programs in Nevada are valuable, several problems for mentally handicapped people were identified from inspection of the program descriptions presented earlier in this chapter. They include unemployment (a rate approximately twice that for people without mental handicaps); little effort to combat significant underemployment (by any vocational service program); too few people served in relation to need (with the possible exception of vocational education services for retarded youth); differential levels of service by geographic area (north-south or urban-rural differentials exist for some handicaps, especially in the VR, CVC, and VT programs); differential levels of service by type of handicap (especially

⁸⁰ Estimated 2-percent prevalence for youth aged 5 to 19 in 1969. U.S. Department of Health, Education and Welfare, *Handicapped Children in the U.S. and Special Education Personnel Required—1968-1969 (est.)*, Bureau of Education for the Handicapped, August 1970.

⁸¹ "Rehabilitation Facility Plan," p. 78.

⁸² For a discussion and review of the literature on the vocational abilities and service needs of retarded individuals, see M. W. Conley, *The Economics of Mental Retardation*, The Johns Hopkins University Press, Baltimore, Maryland, 1973.

the extremely low emphasis on serving severely emotionally disturbed youth in the vocational education program and the low emphasis on serving (or at least referring for service elsewhere) of all types of mentally handicapped people by the Employment Security program); a questionable allocation in FY 1974 of about half the limited available VR funds for service to mentally handicapped people with generally less severe "other mental" disorders (i.e., people who, according to VR definition, are not primarily psychotic, neurotic, retarded, alcoholic, or drug abusing); inadequate facilities (especially for rural Nevadans in their home counties); inadequate short-term residential facilities for rural Nevadans served in Reno and Las Vegas; inadequate referral and coordination between vocational and other types of service programs (especially between VR, ES, and the schools, and between VR and some of the mental health programs); and duplication of program responsibilities (in particular the Vocational Training program overlap with the VR and Community Training Center programs). In the next section we make several recommendations for alleviating these problems.

Vocational Service Recommendations

The Nevada Rehabilitation Facility Plan for 1975-1980 sets the following priorities for vocational rehabilitation facility construction and expansion:⁹⁹

Vocational rehabilitation facilities are needed primarily in the rural areas of the state where virtually no facilities currently exist. Even though the urban areas have the largest numbers of persons in need of services, the priority appears to be in the rural areas where either no services are available or the existing facilities are totally inadequate to serve the need.

Priorities for construction of vocational rehabilitation facilities are:

1. Humboldt County area of North-Central Nevada.
2. Elko and Lander Counties in North-East Nevada.
3. White Pine and Eureka Counties in East-Central Nevada.
4. Clark County to serve the surrounding counties of Esmeralda, Lincoln, and Nye.
5. Northern and Western Nevada including Washoe, Storey, Douglas, Churchill, Lyon and Mineral Counties, and Carson City.

The largest number of facilities to be added or expanded is in Clark County, which needs four additional vocational rehabilitation facilities primarily in the area of sheltered employment. Washoe County needs three additional vocational rehabilitation facilities, also in the area of sheltered employment.

We agree that additional vocational services are needed in rural counties as well as in Clark and Washoe Counties. However, we question whether the specific types, numbers, and locations of facilities mentioned above are the most appropriate. In that Facility Plan the method used to set priorities ranked needs for new, expanded, and modernized facilities according to the percentage of unmet facility needs within service areas. On the surface that approach seems good, but its implementation poses difficulties. After Nevada service areas are defined (as five are

⁹⁹ "Rehabilitation Facility Plan," p. 100.

for Vocational Rehabilitation), the plan implicitly assumes, in making several recommendations, that a full range of services will be provided in facilities in each of the service areas; however, it may be better to send clients to other areas for certain types of services. And when facilities are counted to calculate the percentages of unmet needs, all facilities are counted the same; in setting priorities, however, this means the plan implicitly gives equal weight to a need for a large comprehensive service facility and a need for a small sheltered workshop. That plan projected the minimum number of individuals to be served in 1980 by multiplying the number of people presently served per capita times projected population and then adding an "adjustment" to provide flexibility. Then it projected minimum facility needs by multiplying the projected number of individuals to be served times the number of facilities per number of individuals presently served, plus an "adjustment."²⁴ In several cases the "adjustment" factor was the determinant of the recommendation in facility needs. For example, in both the Humboldt and Pershing County areas and the White Pine and Eureka County area, the Facility Plan for Vocational Rehabilitation calls for construction of a "comprehensive rehabilitation facility with a complete range of services."²⁵

While one should have a complete range of services available to residents of each of the counties, and ideally would like those services available close to the residents' homes, in practical terms one must establish a hierarchy of needs and recognize the quality of services that realistically can be provided in each rural county. In terms of quality of services, it is difficult to obtain specialist staff in every rural county, and those service specialists are in very short supply throughout Nevada. We suggest that rural Nevadans would be better served by a plan calling for the feasible provision in the rural county of (1) more frequently needed but not highly specialized services such as vocational counseling, placement, and follow-up, and (2) long-term sheltered work if needed, while providing short-term (days or weeks) but specialized services and living arrangements for rural Nevadans at comprehensive rehabilitation facilities in Reno and Las Vegas. (Such residential facilities are recommended in the Rehabilitation Facility Plan.)²⁶ We view this as preferable to calling for several comprehensive rehabilitation facilities in rural areas that would be costly and would be difficult to start. That is, we believe the best alternative is to furnish a limited array of good-quality, long-term services to rural Nevadans now in their home counties, backed up by shorter-term and more specialized rehabilitation services in Reno and Las Vegas. Such a middle course is preferable to the current deficiency or nonexistence of rural services, and is preferable to delaying action until the distant day—which may never arrive—when all services can be provided in facilities in rural counties.

In terms of the hierarchy of needs, for example, should the state first build several more comprehensive rehabilitation facilities when it already has such facilities in the north and in the south, or should the state first build a facility for residential care of emotionally disturbed youth in the northern part of the state, where there presently is none? The existing community vocational centers in the rural areas can be characterized as being generally small, without stable funding, occupying inadequate facilities, providing a few but not all types of vocational

²⁴ *Ibid.*, p. 26.

²⁵ *Ibid.*, pp. 88, 90.

²⁶ *Ibid.*, pp. 93-96.

services needed, and with a dedicated staff working extremely hard to meet the needs of developmentally disabled adults. Three distinct options exist: (1) continue the present program and thus partially but inadequately meet vocational needs in rural areas; (2) expand to provide a comprehensive quality program of services in rural facilities; or (3) offer improved long-term services locally in rural areas (e.g., education, competitive or sheltered work, and residence) but develop a cooperative arrangement to send people to the larger metropolitan areas for short-term (weeks) provision of quality specialized services. The Rehabilitation Facility Plan calls for five vocational rehabilitation geographic service areas. *We recommend that (1) a full, comprehensive range of quality vocational services be provided in the Reno and Las Vegas areas and be available equitably to all Nevadans in need, with short-term residential arrangements in those two cities for rural Nevadans, and (2) that in the other three geographic areas a limited range of the more frequently needed, less specialized, and longer-term vocational services be provided.*

For those longer-term activities of daily living, prevocational, vocational, and sheltered-work services currently provided through the several community training centers in the state, we estimate that the costs that will be necessary to provide minimum quality services are currently two to four times as high as the \$1200 per year minimum funding provided per client by the Community Training Center program.⁹⁷ However, in FY 1974 primary funding was provided for some of the 183 adult clients at these centers by the VR program. *We recommend that the Community Training Center minimum funding level per client be at least doubled for those clients receiving services but not primarily funded by the VR program.*

The small Vocational Training program, operated within the Division of Mental Hygiene and Mental Retardation with personnel who have no substantial prior background in vocational service, provides services in northern Nevada that overlap those provided jointly by the VR program and the Washoe Association for Retarded Citizens. *We recommend that the Vocational Training Program be eliminated and its personnel and current clientele transferred to the joint VR-WARC program.*

The special vocational education services to mentally handicapped youth focus almost exclusively on mentally retarded youth. This differential level of service by type of handicap is hard to justify. Some emotionally disturbed youth need and can benefit from special vocational education, too. *We recommend that special vocational education programs be expanded to provide vocational services to some severely emotionally disturbed youth.*

The Department of Employment Security reported serving 337 mentally handicapped people among nearly 2700 handicapped people served in FY 1974; 30 or fewer were referred to the Bureau of Vocational Rehabilitation. *We recommend increasing the number of referrals from the Department of Employment Security to Vocational Rehabilitation of persons suspected of having a mental handicap who are not placed in jobs within a short time. The Employment Security program and personnel are less able to adequately serve the more severely mentally handicapped people than are the VR program and personnel.*

The information needed to manage some of the vocational service programs effectively is severely lacking. For the Vocational Education and Employment Secu-

⁹⁷ The Nevada Association for Retarded Citizens estimates that the present CTC funding covers only 19 percent of the cost, and is officially seeking at least a doubling of current CTC funding per client (as reported in "Retarded Patients to Attend Hearing," Nevada State Journal, March 19, 1975).

rity programs, for example, even the statistics on the number of mentally handicapped people served are of dubious validity. Even in the VR program, which has relatively good information, the real reasons clients are not accepted or are not rehabilitated are not well known, partly because the information categories that can be marked on the forms do not permit the persons filling them out to fully express what they know. For example, although better reasons may be known to VR direct-service personnel, partly because of the design of the form, the reasons most often marked for clients' being not accepted or not served were the clients' lack of response to and/or lack of acceptance of the VR program. More information is needed on why referred persons do not respond and do not accept the VR program before one can say which would be desirable: a revised referral process, or more active outreach efforts, or better program information for referred persons, or a revision of the program to make it more acceptable to mentally handicapped persons, or a combination of these approaches. However, some action is needed to increase the percentage of referrals who are rejected because they are not qualified for service, and decrease the percentage not accepted for the currently prevalent reasons. Again, as with the reasons for non-acceptance of VR clients, better categories and information are needed on reasons for nonrehabilitation, especially reasons for the majority "dropping out." The VR program should take steps to reduce the current high percentage of "dropouts," but whether those steps should include changes in the services offered to better meet the clients' wishes, changes in the occupations for which clients are being rehabilitated, more active attempts to keep clients that show a tendency toward "dropping out," speeding up the time it takes to get through the program, or other actions, clearly depends on information not now available on the reasons for attrition of VR clients. Finally, with the exception of the VR program, effectiveness data for vocational service programs are severely lacking. *We recommend that improved program management and effectiveness information be obtained for each Nevada vocational service program.* This information gathering does not require a really major or costly effort. The present effort in the VR program is more than adequate, although some of the information categories that program uses on forms need revision so they are more illuminating. (This can be done and still be consistent with the federal reporting requirements if categories that are collapsible to the federal categories are used.)

The Chairman of the Nevada Governor's Advisory Board on Rehabilitation has indicated that significant improvement is needed in the incentive system for VR staff, and in cooperation between the VR program and other programs, such as the schools. He said that, for example, the VR liaison people who are working with the schools often do not take a personal interest in their clients, and the VR incentive system is such that the VR counselor receives the maximum reward from the program if a graduating student's VR case is closed by placement into a sheltered workshop. Hence, there is a service-system disincentive, rather than incentive, to providing a client with extensive vocational training and to seeking the highest-level job of which the client is capable. Since case closures are rewarded, he said, VR counselors often do not try to train the clients, but rather try to place them and close their cases.²² A change in incentives for VR counselors would be a clear improve-

²² Interview with Dr. R. Foster, Chairman, Governor's Advisory Board on Rehabilitation, Division of Rehabilitation, Carson City, Nevada, October 25, 1977.

ment. The problem of lack of cooperation between programs offering vocational services and other service programs for mentally handicapped people also clearly needs attention. In all of FY 1974, for example, only 16 mentally disabled youth were referred for vocational rehabilitation by the schools, and were rehabilitated. Not only should those other agencies and service personnel be strongly encouraged to refer certain types of people, but the VR program itself should consider implementing more active outreach activities, especially with respect to the schools, the Department of Employment Security, private physicians, and the public health nurses we noted earlier as having a relatively low referral rate in relation to the number of mentally disabled people they are in contact with. Once service priorities are set, they can be achieved more easily if notification of the types of clients desired is clearly communicated to each referral source, and referral of those clients is actively encouraged at the level of direct service personnel, not solely at the administrative personnel level. There is a passive tendency to serve clients who come to an agency, rather than to set out well-defined priority categories of people who need service and then actively reach out to find them. It would be inexpensive to arrange for automatic referral to or outreach by VR, for example, for all mentally handicapped people served by various programs. Such a stratagem would provide VR with fairly comprehensive rolls of potential clients from which they could select high-priority clients.

One might take a dynamic and flexible approach depending on the level of vocational impairment. For example, all mentally handicapped youth might be screened by VR before leaving school, and mildly handicapped youth might automatically be given both job information and placement assistance upon leaving school, and then if they are not vocationally successful, full VR services could be given. Severely handicapped youth could be automatically offered full VR services beginning well before their scheduled departure from school (which is permissible under Federal regulations). Whatever the priorities assigned, the program will come closer to meeting its goals with its available resources if effort is concentrated on finding, accepting, and serving clients in priority categories.

The VR program does not usually send clients to ES for placement, because it has its own placement network. Presently, the VR counselor has access to the ES job bank file. If VR clients' placement needs were made known to the ES Department, it would be possible to alert and enlist the aid of ES staff in placement of mentally handicapped people not only in job-bank positions but also in new positions developed. Also, some clients use both the VR and ES agencies simultaneously without telling each agency, so as to maximize their chances of getting a job. Thus, to avoid duplication of effort and achieve better coordination, better information is needed on who is a client of which agency, as well as on job availability. Information privacy regulations are essential, but should not unnecessarily impede the effective delivery of services to individuals.

We recommend improved outreach and referral among vocational service programs and other nonvocational programs serving mentally handicapped people. In particular, we recommend increased numbers of referrals to Vocational Rehabilitation of mentally handicapped youth leaving school, working-age clients of the income assistance programs, and unemployed working-age clients of the NMHL, the Mental Retardation Centers, the Mental Health Centers, the Rural Clinics program, the Community Training Centers, private psychiatric service programs, and alcohol and drug abuse programs. We discussed referrals from the Department of Employment Security above. Although the VR program does not now have sufficient resources to

serve all those in need, an increase in referrals would permit screening and acceptance of more *high priority* types of clients.

The Vocational Rehabilitation program is not now serving all those in need because of mental health problems, mental retardation, and alcohol or drug abuse. This program improves the quality of life of mentally handicapped people by increasing their ability to function independently, to obtain employment, and to work at higher-quality employment. It also appears to yield economic benefits to society (reduced service cost later in life, reduced welfare, increased taxes paid, and increased earnings) that exceed the costs of the program. Even with assumptions designed to subject the program to a difficult test, the economic benefits exceed costs to society as a whole and to the taxpaying population for every one of the eight categories of prevalent types of mental handicaps that we considered. A recent General Accounting Office report on the VR program nationwide indicated that "the number of persons needing vocational rehabilitation services has far exceeded the number of persons that have been served under the program" and that "the number of persons rehabilitated annually, although increasing, is still not as great as RSA's estimates of the number becoming eligible each year."²² The unmet need in Nevada is also large, and the gap can be narrowed either by expanding the VR program or shifting priorities on the types of people served. The Nevada Bureau of Vocational Rehabilitation must set its own priorities subject to federal funding guidelines, but we question whether placing highest priority on people with psychoneurotic or "other mental disorders" (as evidenced by their being the two largest categories in FY 1974 in terms of numbers of clients accepted and average cost of services per rehabilitant) is consistent with current federal guidelines giving priority to more severely handicapped people. In fact, half of all VR case expenditures on mentally disabled individuals whose cases were closed in FY 1974 went for persons in the nebulous category "other mental disability"—people who were not disabled by alcoholism, drug abuse, mental retardation, psychosis, neurosis, epilepsy, cerebral palsy, Parkinson's Disease, or stroke according to VR definitions. We do not doubt that people with other mental "disorders of character, personality, or behavior" need and deserve service, but the Division of Rehabilitation may wish to concentrate its resources more heavily on more severe mental disorders, in line with current Federal guidelines. Since all those in need cannot be served with the resources available, we suggest that the division enforce explicit priorities for the acceptance of people with the different types and degrees of mental disorders. Adjustments in the referral process, and perhaps active seeking of certain types of clients from other agencies, may be necessary to implement the priorities that are set. For example, the division could not greatly increase the number of mentally retarded people served simply by deciding to accept more retarded clients, since they received only 55 more referrals than were accepted, according to FY 1974 closure statistics; the division also would have to take action to increase the number of referrals of retarded persons.

Looking at the various types of mentally disabled persons rehabilitated in FY 1974 by source of referral also raises certain questions of priorities. For example, should half the rehabilitants from the mental hospital be alcohol or drug abusers?

²² *Effectiveness of Vocational Rehabilitation in Helping the Handicapped*, Report to Congress by the Comptroller General of the United States, Number B-164031 (3), April 3, 1973.

Should over half the rehabilitants from mental health centers be classified by VR as having some "other mental disorder" of character, personality, or behavior rather than being psychotic or psychoneurotic? Should over 80 percent of the rehabilitants referred by the public health personnel be drug abusers? The answers to these questions clearly depend on priorities set implicitly or explicitly by the VR and other programs. While certain VR offices such as the Public Offender Outreach office and the NMHI office must specialize in certain types of disabilities by virtue of the special population from which they are intended to draw clients, other offices that are supposedly serving the general population in an equitable manner probably should not specialize except according to the overall priorities of the Nevada Bureau of Vocational Rehabilitation. For example, how do the Henderson and Las Vegas Mental Health Outreach offices justify the heavy emphasis on drug addiction and other mental disorders relative to the emphasis on psychosis, psychoneurosis, and alcoholism? More explicit guidelines and priorities, or enforcement of existing guidelines and priorities, appear to be required from the Bureau of Vocational Rehabilitation. *We recommend either expansion of the VR program to serve more of the severely mentally handicapped people in need, or restructuring FY 1974 priorities to shift the VR caseload from emphasizing the generally less severe "other mental" handicaps toward emphasizing the more severe mental handicaps without increasing the total budget.* The quality of life benefits of successfully serving more severely handicapped people can be substantial, and our detailed analysis indicates such service can be justified in an economic benefit/cost sense for all but the most severely handicapped people. Our analysis suggests that benefits in relation to costs may actually rise with

Table 11.18

ALTERNATIVE VOCATIONAL SERVICE LEVELS FOR MENTALLY
HANDICAPPED NEVADANS, 1974 AND 1985

Number Served and Expenditures	Status Quo		Reallocation of Resources		Geographic Equity		Minimal Need	
	Maintain 1974 level of services per capita		Shift status quo level of resources among and within programs		Raise level of services per capita in each of three regions to level of best-served region		Provide current quality services in each program to meet conserva- tively estimated need per capita	
	1974	1985	1974	1985	1974	1985	1974	1985
Number served ^a								
Mental health	161	214	561	746	177	235	580	773
Mental retardation	635	845	635	645	717	954	750	1000
Alcohol and drug abuse	140	186	140	186	183	243	280	347
Other mental	296	394	296	394	296	394	296	394
Total	1232	1639	1632	2171	1373	1826	1906	2514
Expenditures (in \$ million)	\$2.757	\$3.667	\$2.757	\$3.667	\$2.792	\$3.723	\$4.536	\$6.046

^aExcluding those served by the Department of Employment Security, for whom we do not have data by type of handicap.

the severity of handicap and hence with the initial vocational skill deficit of the person (up to a point in severity where preparation for any job is extremely difficult). In a February 24, 1976, letter to The Rand Corporation, Del Frost, Administrator of the Division of Rehabilitation, indicated that priorities had been shifted toward serving more severely handicapped people. His Division's quantitative analysis of data from FY 1975 and the first half of FY 1976, when made available to the public, will allow assessment of the degree to which this shift in priorities has occurred.

Looking at four basic options displayed in Table 11.18, note that if Nevada does no more than maintain, until 1985, the status quo level and quality of vocational services per capita, and the same programs, vocational service expenditures will rise from \$2.76 to \$3.67 million per year. There are many ways to implement the option of reallocating resources within and among the vocational service programs without increasing total annual expenditures—the second alternative listed in Table 11.18. Adjustments in the numbers of people served under that alternative will allow implementation of several of our recommendations: the Vocational Training program can be phased out and its clientele and personnel transferred to other programs; minimal services of the vocational education type can be initiated for 400 severely emotionally disturbed youth per year in schools (this might have to be done partially by the VR program, since federal VR funds are not directly transferable to the Vocational Education program); improved management and effectiveness data can be obtained; improved referral mechanisms can be implemented; and the VR program service for people with "other mental" disorders is assumed to be cut in half,¹⁰⁰ allowing VR service to 250 more severely handicapped people per year (we assume more service to retarded people in Table 11.18 for illustrative purposes only). The "geographic equity" option—raising the level of service per capita in each program in each of the three major regions (Clark, Washoe, and all other counties combined) to the current level in the best-served region—would result in a small increase in total cost. The geographic equity option could be implemented in a hybrid fashion together with the reallocation of resources option, resulting in substantial vocational service improvements in Nevada at rather nominal added cost. The "minimal need" option assumes implementation of all of the recommendations of the reallocation of resources and geographic equity options, plus doubling the level of Community Training Center funds per person served and providing the current quality services to that number of people with mental health problems, mental retardation, and problems of alcohol or drug abuse we estimated earlier to be in need. While the total number of people served for some types of mental handicaps does not substantially increase from the reallocation of resources to the minimal need option, the expenditures for those people increases considerably as they are provided more services in the VR program with higher expenditures per capita. The annual expenditures to meet the minimal need in each program retained would be approximately \$4.5 million in 1974 and rise with population growth to \$6 million in 1985.

¹⁰⁰ About 40 percent of the VR clients with an "other mental" disorder of character, personality, or behavior were on public assistance at time of referral.

Chapter 12

MEDICAL SERVICES

Nevada's medical service programs for mentally handicapped people can affect their lives importantly in two ways: by providing treatment for the physical health needs of people who have mental health, mental retardation, or substance abuse problems, and by providing payments for both physical and mental health services. This chapter first gives an overview of medical personnel and facilities in Nevada. It then discusses programs providing medical treatment or payment, including Medicare, Medicaid, private insurance, the Crippled Children's Services program, and the Easter Seal Treatment Centers. The chapter concludes with recommendations for improvement.

The various programs discussed expend about \$50 million a year in public funds in Nevada. All but a small percentage of that amount comes from Medicare (\$27 million) and Medicaid (\$22 million), and about three-fourths of the total is federal money. Private sector expenditures for medical care are not known, nor are the fractions of public expenditures devoted to mental health services and other medical care to Nevadans with problems of mental health, mental retardation, or alcohol or drug abuse. Program records typically are not kept in such a way as to enable the identification of, for example, a mentally retarded person being served. The only funds we can specifically identify as going for service to clients with mental problems are about \$282,000 in Medicaid funds for mental health services (identifiable because they went to mental health service personnel), and about \$75,000 in Easter Seal Treatment Center funds for mentally retarded clients. Obviously, more money than that went for people with mental problems, but we can only estimate the total. One might assume for lack of better data, for example, that the fraction of Medicaid and Medicare recipients who are mentally handicapped is the same as the fraction in the total Nevada population (see Chap. 3), and that average expenditures for a mentally handicapped client are about the same as for all other types of clients. Under those assumptions, the programs annually expend about \$1 million for people with mental health problems, \$1 million for mentally retarded people, and \$4 million for alcohol and drug abusers. We caution that these are only order of magnitude estimates, based on rather tenuous assumptions made in the absence of better information.

Other chapters of this report cover certain types of medically related services, and medical services provided by programs whose primary purpose is nonmedical. Prevention of mental handicaps is discussed in Chap. 5. Identification and diagnosis of handicaps is the subject of Chap. 6. Psychiatric services, including drug therapy for mental health problems, are covered in Chap. 8. Chapters 10 and 11, respectively, include a discussion of medical services provided by residential treatment programs for mentally handicapped people (such as the Nevada Mental Health Institute) and by the Vocational Rehabilitation program.

OVERVIEW OF MEDICAL PERSONNEL AND FACILITIES

The geographic distribution of medical facilities and personnel is a general problem for many Nevada residents in rural areas and a specific problem for the mentally handicapped population. This is so because medical personnel are responsible, in varying degrees, for identifying, diagnosing, and referring mentally handicapped people for other needed services. Furthermore, while all people have medical needs, certain types of mentally handicapped people have special medical needs beyond initial diagnosis and referral; severely mentally retarded people, for example, often have accompanying physical impairments. Transportation to obtain medical services can be a problem for all rural Nevadans, but it is especially serious for people who need highly specialized medical services and may have to journey several hundred miles to Reno or Las Vegas to obtain them.

Medical Personnel

About 740 physicians practiced in Nevada in the summer of 1975. A two-year-old program to train physician's assistants to relieve the relative shortage of doctors in rural Nevada has thus far had little effect. Of the ten physician's assistants trained since 1973, only five have remained with their supervising doctors, and of these, three practice in rural areas.

Some of the gap is filled by public health nurses, who provide skilled nursing and related services to both individuals and groups in the home, schools, and public health centers. These nurses provide such services as pre- and postnatal counseling; immunization clinics; family planning counseling; home care; and investigation, testing, and follow-up for tuberculosis control. In 1974, approximately 16 public health nurses serviced 15 rural counties.

Medical Facilities

Table 12.1 lists 27 Nevada hospitals along with their location, bed capacity, and average daily census (1974 data). Only twelve offer any mental health services, and seven of those are on an emergency or partial hospitalization basis only (see Chap. 10 for details). Outside of Reno and Las Vegas, only emergency mental health services are available, and then not at most of the hospitals, according to the American Hospital Association Guide.

Long-term-care hospital facilities listed by the American Hospital Association include William Bee Ririe Hospital (35 long-term beds, East Ely), Elko General Extended Care Unit (19 beds), Pershing General Hospital Extended Care Unit (25 beds, Lovelock), Beverly Manor Convalescent Hospital (size not listed, Las Vegas) and the Veteran's Administration Center Nursing Home Care Unit (size not listed, Reno).¹

Table 12.2 lists 18 facilities that provide continuous skilled nursing service, under medical direction, to convalescent patients not in an acute episode of illness. The facilities are licensed by the Nevada Health Division.

Nevada defines an intermediate care facility as

...an establishment operated and maintained for the purpose of providing personal and health care supervision, plus 24-hour awake supervision, for

¹ American Hospital Association, *Guide to the Health Care Field*, Chicago, Illinois, 1974 ed.

Table 12.1
NEVADA HOSPITALS, 1974

Hospital	Location	Beds	Daily Census	Psychiatric Service
Boulder City	Boulder City	33	13	No
Carson City	Carson City	75	56	Emergency only
William Bee Ririe	East Ely	79	45	Emergency only
Elko General	Elko	74	70	No
Churchill Public	Fallon	42	22	No
Battle Mountain General	Battle Mountain	(?)	(?)	(?)
Mount Grant General	Hawthorne	37	19	Emergency only
Rose de Lima	Henderson	80	42	Emergency and partial hospitalization
Desert Springs	Las Vegas	100	59	Emergency only ^a
So. Nevada Memorial	Las Vegas	287	205	Inpatient and emergency
Las Vegas Mental Health Center ^b	Las Vegas	40	29	Yes
Sunrise	Las Vegas	115	287	No
Valley	Las Vegas	269	(?)	No
Womens	Las Vegas	49	39	No
Cedarbrook ^c	Las Vegas	21	11	Inpatient
Pershing General	Lovelock	47	21	No
U.S. Air Force	Nellis AF Base	50	28	No
No. Las Vegas	Las Vegas	99	(?)	No
U.S.P.H.S. Indian	Owyhee	16	7	No
U.S.P.H.S. Indian	Schurz	26	11	No
St. Mary's	Reno	285	223	Emergency only
Veterans Administration	Reno	177	154	Partial hospitalization
Washoe Medical	Reno	417	303	Inpatient, partial hospitalization and emergency
Nye General ^b	Tonopah	(?)	(?)	(?)
Nevada Mental Health Institute	Sparks	484	358	Yes
Humboldt Co. General	Winnemucca	45	(?)	No
Lyon Health Center	Yerington	42	32	No

SOURCE: American Hospital Association, *Guide to the Health Care Field*, 1974 ed., Chicago, Illinois.

^aClark County Areawide Comprehensive Health Planning Advisory Council, *Clark County Plan for Health*, Las Vegas, Nevada, December 1974.

^bLicensed by Nevada Health Division but not listed in AHA *Guide*.

^cInterview with T. Mikkelsen, Administrator, Cedarbrook Hospital, Las Vegas, Nevada, October 31, 1974.

four or more individuals who do not have illness, disease, injury, or other conditions that would require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide.¹

Table 12.3 lists nine such facilities, all licensed by the Nevada Health Division.

Note that only 12 of the 17 Nevada counties have skilled nursing facilities, and only 4 have intermediate care facilities. Apart from geographic considerations of availability of services, several people we interviewed alleged that the operators of some of these facilities, which serve the general public, find ways in practice of

¹ Nevada Revised Statutes 449.025.

Table 12.2

SKILLED NURSING FACILITIES IN NEVADA

Facility	Location
Carson Convalescent Center	Carson City
Fallon Convalescent Center	Fallon
Beverly Manor Convalescent Hospital (148 beds)	Las Vegas
El Jen Convalescent Hospital (31 beds)	Las Vegas
Las Vegas Convalescent Center (77 beds)	Las Vegas
Rancho Vegas Nursing Center, Inc. (86 beds)	Las Vegas
Vegas Valley Convalescent Hospital (79 beds)	Las Vegas
Elko General Hospital	Elko
Humboldt General Hospital	Winnemucca
Battle Mountain General Hospital	Battle Mountain
Lyon Health Center	Yerington
Mount Grant General Hospital	Northrop
Nye General Hospital	Primm
Perkins General Hospital	Primm
Physician's Hospital for Extended Care	Reno
Reno Convalescent Center	Reno
Riverside Hospital for Extended Care	Reno
William Bee Ririe Hospital	E. Ely

SOURCES: Rehabilitation Division, Nevada Department of Human Resources, *Rehabilitation Facility Plan, 1975-1980*, Carson City, Nevada, January 1, 1975; Clark County Area-wide Comprehensive Health Planning Advisory Council, *Clark County Plan for Health*, Las Vegas, Nevada, December 1974.

Table 12.3

INTERMEDIATE CARE FACILITIES IN NEVADA

Facility	Location
Ruby Mountain Manor	Elko
Fallon Convalescent Center	Fallon
Golden Age Gardens	Reno area
Northern Nevada Mental Retardation Center	Reno area
Vegas Valley Convalescent Hospital (20 beds)	Las Vegas area
Gaye Haven ICF (30 beds)	Las Vegas area
Glen Halla ICF (24 beds)	Las Vegas area
Torrey Pines Care Center (116 beds)	Las Vegas area
Southern Nevada Mental Retardation Center	Las Vegas area

SOURCES: Rehabilitation Division, Nevada Department of Human Resources, *Rehabilitation Facility Plan, 1975-1980*, Carson City, Nevada, January 1, 1975; Clark County Area-wide Comprehensive Health Planning Advisory Council, *Clark County Plan for Health*, Las Vegas, Nevada, December 1974.

denying admission to mentally handicapped clients. Consequently, services may not be accessible to mentally handicapped people even if a facility exists.

With regard to the organization of medical service programs, within the Nevada Department of Human Resources, the Office of the State Health Officer's Bureau of Health Facilities is responsible for licensing all health and care facilities (hospitals, skilled nursing facilities, intermediate care facilities, adult group care facilities, child care facilities, home health agencies, and alcohol and drug abuse treatment centers). The Bureau of Maternal, Child and School Health, in the same office, is responsible for the operation of several programs, including the Crippled Children's Services program described later in this chapter, and the Special Children's Clinics for developmentally disabled children described in Chaps. 4, 6, and 7. The office of the State Health Officer's Bureau of Community Health Services provides the public health nurses mentioned above, and through them some of the prevention services we described in Chap. 5. The office is also responsible for the state's comprehensive health planning.

Outside the office of the State Health Officer, the Medical Care Unit of the Nevada Division of Welfare operates the Medicaid program, and the Division of Mental Hygiene and Mental Retardation employs numerous health personnel and also purchases some medical services for clients of the Nevada Mental Health Institute, the Mental Retardation Centers, and the Mental Health Centers. Finally, the Division of Rehabilitation funds some medical services for clients of the Bureau of Vocational Rehabilitation and of the Bureau of Alcohol and Drug Abuse through grants to local agencies.

We now turn to a discussion of some of the Nevada programs that provide medical services with the personnel and facilities just reviewed.

MEDICARE

With the federal Social Security Amendments of 1965, access to health care was greatly expanded for most Americans 65 years of age and older. The Amendments of 1972 (P.L. 92-603) extended Medicare coverage to Social Security disability beneficiaries who had been entitled to disability benefits for at least 24 consecutive months.

Under Part A of Medicare (hospital insurance), coverage for inpatient care in a certified general hospital is the same whether the ailment is physical or mental. Up to 90 days of inpatient care in a participating general hospital are covered in a benefit period. (There must be a 60-day interval between benefit periods when the insured is an inpatient in any health facility.) A deductible of \$92 and a copayment of \$23 per day after the first 60 days are required. (Data are for calendar year 1975.) A lifetime reserve of 60 days can be used to extend any benefit period. The copayment for each reserve day is \$46. In addition, Part A of Medicare provides coverage for up to 100 days in a certified skilled nursing facility in each benefit period following a hospitalization of at least three days. A copayment of \$11.50 per day is required after the first 20 days. A patient is also entitled to 100 home health visits within one year following at least three days of inpatient care.

However, Medicare has built-in restrictions specific to mental health disorders. Although Medicare pays for inpatient treatment in a psychiatric hospital (which it

defines as one whose primary purpose is to treat mental diseases), this coverage is limited to 190 days in a lifetime. Coverage cannot be extended by the 60-day lifetime reserve available for other types of hospitals. In general hospitals that may have psychiatric beds, Medicare benefits are the same for psychiatric patients as for other patients. The reasoning behind this rather arbitrary restriction is to exclude payment for custodial care.

One effect of the restriction has been noted by the President's Task Force on the Aging, which contends, "... that the 190-day lifetime limit under Medicare for inpatient treatment in a psychiatric hospital should be removed, since the limitation on inpatient care in a psychiatric hospital ... for those older persons who experience acute or recurring emotional disturbances is neither humane nor realistic. Nor is it medically sound if it results in the premature transfer of the older person after 190 days of treatment into a custodial care situation. It is also inequitable when compared with Medicare provisions for care of chronic or acute organic illness."³ To make matters worse, home health visits may not be provided by agencies primarily characterized as mental health service providers.

The "Part B" portion of Medicare is an optional, supplementary medical insurance program. Under it, a person with a psychiatric diagnosis is covered on the same basis as that for any other diagnosis as long as hospital inpatient status is maintained. A person receiving psychiatric treatment as an inpatient in a nursing home or intermediate care facility is viewed as an outpatient—the same as if the person were treated in a physician's office or the outpatient clinic of a hospital; and as such, Medicare payment is limited to 50 percent of the charges up to a maximum of \$250 per calendar year. This limitation applies to both doctors' fees and other items and supplies furnished in connection with the treatment. On the other hand, psychiatric services provided in an organized health care setting by health personnel other than physicians, but under the supervision of a physician, are not subject to the special psychiatric limitations. In addition, up to 100 home health visits, not subject to a requirement for prior hospitalization, are covered in addition to those services available in Part A. These visits can be provided by agencies whose primary purpose is the treatment of mentally handicapped people.

Part B of Medicare unduly limits mental health services in several ways. Given standard psychiatric fees, \$250 buys very little. Furthermore, hospitalization is encouraged for psychiatric services that could under some conditions be provided equally as well in an outpatient clinic, at lower cost to Medicare.

Community Mental Health Centers are not certified as separate service providers under Medicare. If their inpatient facilities do not have certification as a Medicare-participating hospital, the physician providing inpatient services is subject to the \$250 annual limitation for outpatient services.

For FY 1974, Medicare provided medical services to aged and disabled Nevadans at a total cost of \$27 million: \$22 million for the Part A program and \$5 million for Part B. These monies were distributed among about 42,000 persons: 3555 disabled and 38,219 aged. Of this group, 37,154 of the elderly and 3282 of the disabled chose to protect themselves with the optional Part B insurance.⁴ The Title XIX

³ U.S. Department of Health, Education, and Welfare, Social Security Administration, Office of Research and Statistics, *Financing Mental Health Care Under Medicare and Medicaid*, Research Report No. 37, Washington, D.C., p. 16.

⁴ Data provided by Sandy Kurlich, Bureau of Health Insurance, U.S. Department of Health, Education, and Welfare, Regional Office, San Francisco, California, 1974.

Medicaid program buys the Medicare deductible and co-insurance for people on Medicaid.

Available data on the Medicare program do not show how many clients were mentally handicapped, nor how many people utilized mental health services, nor how much was expended on them. However, general points about the program can be noted.

The use of the general hospital as a resource for psychiatric care of the elderly has been expanded. But federal regulations have hampered the delivery of mental health care by imposing a \$250 limit on reimbursement for outpatient psychiatric services. This limitation not only discriminates on the basis of diagnosis, but also restricts what may be necessary treatment and promotes inappropriate use of more costly inpatient care. In addition, the 190-day lifetime limit both discriminates against treatment for mental disorders and denies treatment to people in need.

Those who either cannot afford private care or who are not eligible for Medicare (most younger people are not) may turn to Medicaid. For those who are eligible, Medicare coverage must be exhausted before Medicaid funds are made available.

MEDICAID

Medicaid is a joint federal-state funded assistance program that provides for medical care to persons in federal-state categorical financial assistance programs, and to some others.⁵ Unlike Medicare, benefits under Medicaid are available only to the financially needy. Because this program is a joint venture between the federal and state governments, states have much leeway in determining both the scope of services provided and the eligibility requirements. The Nevada Legislature has enacted legislation that allows participation in this program. The Nevada Medicaid program, known as State Aid to the Medically Indigent (SAMI),⁶ is administered by the Nevada Welfare Division.

Eligibility

To be eligible for Medicaid in Nevada, a person must fall into one of the following categories:⁷

1. Recipients of Aid to Dependent Children (ADC).⁸
2. Recipients of Supplemental Security Income (SSI), including persons over 65 years old in state tuberculosis or mental institutions.
3. Persons under 21 years of age, medically indigent but not eligible for ADC, who belong to a group classification that the State Welfare Board has determined can benefit by medical or remedial care. These persons include unmarried mothers under 21 years of age and in foster home care or in private institutions at public expense, and children in foster home care or private institutions paid by public agencies.

⁵ Title XIX of the Social Security Act, 42 U.S.C.A.

⁶ Nevada Revised Statutes 438.150 to 438.370 inclusive.

⁷ Specified by Nevada Revised Statutes 438.370(3).

⁸ A complete description of those who qualify for inclusion as categorically needy in this and other financial assistance programs follows in Chap. 14, "Income Assistance."

4. Persons in hospitals, nursing homes, and intermediate care facilities who have countable incomes up to 300 percent of SSI benefit level and who otherwise meet SSI eligibility criteria.⁹

It should be noted that a large group of the nonwelfare poor are excluded from Medicaid benefits. These are the medically needy,¹⁰ whom Nevada has an as yet unexercised option of including in the SAMI program. Were these people covered by SAMI, 50 percent federal matching funds would be available. As things stand now, several counties have recognized and are filling the need to provide free medical care to the indigent. Clark County operates its own medically needy program with 100-percent county funding. In this program, although physicians' services are not paid for,¹¹ other necessary medical needs become county responsibility. In Clark County, however, expenditures for special mental health and mental retardation services are primarily (1) fees at the psychiatric wing of Southern Nevada Memorial Hospital until the indigent is transferred to the Nevada Mental Health Institute or the Las Vegas Mental Health Center,¹² and (2) medical costs for severely and profoundly mentally retarded children, ages 0 to 2, until they are old enough to be eligible for acceptance by the Nevada Mental Health Institute. Washoe County covers indigent medical expenses in the outpatient clinic of the Washoe Medical Center and will buy psychotropic drugs; they consider mentally retarded people to be the state's legal responsibility, however.

Since Clark County has the most fully developed "medically needy" program, and since over 50 percent of the state's population lives in Clark County, the State Welfare Division conducted a study of costs of supporting the medically needy program in Clark County in order to project costs of such a program if adopted by the state. Expanded to statewide coverage, estimates of the state's share (50 percent) of increased SAMI expenditures (including doctors' fees) ranged between \$1.6 million and \$2.5 million.¹³

Funded Medical Services

Federal law requires that states providing Medicaid cover seven basic services: inpatient hospital services (other than services in an institution for tuberculosis or "mental diseases"); outpatient hospital services; other laboratory and X-ray services; skilled nursing home services (other than services in an institution for tuberculosis or "mental diseases") for persons aged 21 or older; physicians' services, whether furnished in the office, the patient's home, hospital, a skilled nursing home, or elsewhere; early and periodic screening for persons under 21 years of age; home health care services for any person who, under the state plan, is entitled to skilled nursing home services.¹⁴ Compared with many states, Nevada is quite liberal (with

⁹ This recent ruling (fall of 1974) provides coverage retroactive to January 1974.

¹⁰ "Medically Needy. (1) An individual is considered to be medically needy if he has income and resources which exceed the amount of income and resources allowed to the categorically needy but which are insufficient to meet the costs of necessary medical and remedial care services."

¹¹ As a condition to serving on the staff of Southern Nevada Memorial Hospital, physicians must agree to provide free medical care to indigent patients.

¹² Clark County Welfare has an annual budget of \$175,000 for this purpose.

¹³ "Final Report of the Subcommittee for Study of Consolidation of State and Local Welfare Programs," Legislative Counsel Bureau, Carson City, Nevada, September 1974 (unpublished).

¹⁴ U.S. Department of Health, Education, and Welfare, *Characteristics of State Medical Assistance Programs Under Title XIX of the Social Security Act*, Washington, D.C., 1970.

respect to coverage once eligible, but not with respect to eligibility), by choosing to include several of the coverage options available.

For mentally handicapped people in need of care *who qualify for SAMI*, the following major rules of coverage apply. Care is covered in the Nevada Mental Health Institute *only for people 65 years of age and over*; however, the age restriction does not apply to psychiatric care in a general hospital. All drugs prescribed by a licensed physician are covered. Psychiatrists' fees are covered *without* prior approval of the Medical Care Section of the Nevada Welfare Division, but psychologists' fees are covered *only with* prior authorization of the Medical Care Section. Early and periodic screening and diagnosis for mental handicaps in those *under 21 years of age* are covered. (See Chap. 6 for details.) Skilled nursing facility services are covered for patients *65 years of age or older* "who would not have been discharged from or who would be admitted to an institution for mental diseases if such services were not available to them."¹⁵ Care in intermediate care facilities is covered for mentally retarded people. (This optional federal coverage was adopted by the State Welfare Board in July 1974.) Home health care is covered with prior authorization by the Medical Care Section. (Although there are no limitations on the amount of home health care, providers are limited to the Nevada Home Health Agency in the north, and the Clark County Health Department in the south.)

Expenditures

Medicaid is an open-ended program, with federal funds available without a maximum limit to Nevada on a 50-50 basis for the medical services included in the SAMI program. Counties contribute to SAMI through an annual local property tax levy of 11 cents per \$100 of assessed valuation.

For fiscal years 1973 and 1974, state appropriations for the SAMI program were approximately \$6.9 and \$7.8 million. The estimated proceeds of the 11-cent county ad valorem tax levy (NRS 428.370) totaled \$2.8 million in 1973-1974 and \$3.1 million in 1974-1975. Adding on the estimated 50-percent federal matching amount, the total amount budgeted for SAMI was approximately \$19.6 million for FY 1973 and \$22.1 million for FY 1974.¹⁶

Of these monies, overall Medicaid inpatient costs for psychiatric services for 1973 were \$233,872; outpatient costs for psychological and psychiatric treatment were \$48,469.¹⁷ Not counting psychotropic drugs, mental health accounted for about 1½ percent of Medicaid expenses in FY 1973.

Most psychiatrists and psychologists in Nevada have signed an agreement with the Welfare Division to serve Medicaid patients. An examination of the Medicaid computer files shows that the number of Medicaid patients seen by these private mental health service professionals in a year varies from 1 to 103, with a median of 4 such patients per practitioner.

Medicaid fee schedules are based on "usual and customary" rates for an area; Medicaid pays \$42.50 an hour to psychiatrists and \$27.50 an hour to psychologists.

¹⁵ "Eligibility, Coverage and Limitations," *Medicaid Manual*, Section 103.4, May 3, 1974.

¹⁶ Legislative Counsel Bureau, *Final Report*.

¹⁷ "Money Spent on Mental Care by Medicaid for 1973....," memorandum from Minor Kelso, Chief of Medical Care Services, Nevada Welfare Division, to B. LaBodie, Deputy Administrator for Social Services, Carson City, Nevada, January 25, 1974.

A comparison of the actual billings to Medicaid versus the payment schedule shows a reasonably close match between the two. On the average, Medicaid pays all but about 8 percent of the amount billed by psychiatrists and psychologists.

Since mental retardation per se is not used as a base for determining Medicaid eligibility or for billing, data are not collected or available for mentally retarded Medicaid recipients. However, using the 2-percent incidence figure for the general population (see Chap. 3), we estimate that at least 2 percent of Medicaid dollars aided mentally retarded people in Nevada in 1974. Adding the 1½ percent spent on psychologists' and psychiatrists' services, plus an allowance for psychotropic drugs and other services, we estimate that at least 4 percent of Medicaid funds (but probably not more than 8 percent) went for service to people with mental retardation or mental health problems. For FY 1974, that would amount to approximately \$900,000.

PRIVATE MEDICAL INSURANCE

Although we inquired about private insurance expenditures for Nevadans with mental problems, no specific data were available. A check of various insurance companies confirmed that private health insurance often either excludes or provides more limited coverage for mental health problems than for physical health problems. When it does cover mental health services, it often provides lower benefits for treatment in mental hospitals than for treatment of the same affliction in general hospitals. Drug addiction and alcoholism are typically covered under mental health provisions.

The 1975 Nevada legislative session passed certain measures pertaining to private medical insurance that are beneficial to the mentally handicapped population.¹⁸ Assembly Bill 112 provides that health insurance of newborn children must begin at birth so that mental handicaps present at birth are covered. In addition, Senate Bill 588 provides that health insurance policies must provide at least a specified amount of coverage for alcohol and drug abuse treatment. However, similar mandatory coverage in private health insurance does not exist for mental health and mental retardation.

CRIPPLED CHILDREN'S SERVICES

The Crippled Children's Services program (CCS) provides medical services with federal financial support to handicapped youth in financially needy families. Officials in each state determine which handicapped persons to serve and what the level of financial need should be. The word "crippled" in the program title is a misnomer, since the program can service handicapped youth with virtually all types of medical problems.

In Nevada, the Crippled Children's Services program is part of the Bureau of Maternal, Child and School Health of the Division of Health. Since Nevada has no

¹⁸ Information provided by B. Rose, legislative liaison person with the Nevada Division of Rehabilitation, Carson City, Nevada, June 10, 1975.

legislated definition of a "crippled child," the following administrative definition is used. A crippled child is

a person under 21 years of age, who, by reason of some remediable deformity or defect, whether congenital or the result of accident, injury, or disease, is or may become totally or partially incapacitated.

To be accepted for care under the program, the child must either have one of the following handicapping conditions or be suffering from a disease which, if not treated, is likely to lead to one of these conditions:

- Those of an *orthopedic nature*: Examples: Clubfoot, poliomyelitic paralysis, cerebral palsy, etc.
- Those requiring *plastic reconstruction*: Examples: Cleft palate and cleft lip, contracture or disfigurement due to burns, etc.
- Those requiring *orthodontic reconstruction accompanying cleft palate*.¹⁹

Also included are:

- *Eye conditions* requiring surgical treatment: Examples: Cataract, strabismus, ptosis, etc. Ordinary refractive errors are excluded as are conditions not requiring surgical treatment. The policy of furnishing only one pair of glasses will be continued. However, the glasses may be furnished before surgery or post surgery depending on the advice of the attending ophthalmologist.
- *Ear conditions* leading to the loss of hearing: Examples: Chronic otitis media, chronic blockage of eustachian tubes, congenital deafness, etc. As part of this program, a small number of hearing aids will be furnished to children selected by the otologist and speech pathologist.
- Any *neoplastic conditions* requiring surgery or hospital treatment.
- *Congenital heart conditions* in which special cardiac studies and surgical treatment are indicated. All Nevada children who require special diagnostic care and surgery are referred to the cardiac centers in California, mainly in San Francisco, Los Angeles, and Sacramento.
- *Rheumatic fever* or any condition which may cause rheumatic heart disease.
- *Convulsive disorders*: Short term hospitalization for special diagnostic tests and short term treatment will be provided for selected cases of children with uncontrolled convulsive disorders.

Children who are mentally retarded or have some other mentally handicapping conditions are served only if they fall into the above categories.

Cases are selected for treatment by the Chief of the CCS on the basis of the relative urgency of the case and on the socioeconomic status of the patient's family. Referrals come from multiple sources, such as private doctors, public health nurses, the Welfare Division (adoptive newborn cases born with defects), the Nevada Mental Health Institute (NMHI), and the Nevada Children's Homes. An orthopedic clinic

¹⁹ Nevada Department of Health, Welfare, and Rehabilitation, *Children's Bureau State Health Plan*, Reno, Nevada, July 1, 1969-June 30, 1970, pp. 23-24.

service is provided twice a year to children in the mental retardation section of the NMHI.

Since CCS is financially unable to meet all the medical needs of the eligible population, referrals are made to other services, e.g., Easter Seal Treatment Centers, SAMI, and psychiatrists and psychologists who are full-time employees of the Nevada Department of Human Resources.

Unlike the Medicaid program, CCS is closed-ended, with a fixed annual budget inadequate to meet the need. One-half of the amount appropriated for each year is apportioned among states on the basis of a uniform grant of \$70,000, and an additional grant in proportion to the number of live births in the state. Amounts awarded must be matched dollar for dollar. In FY 1974, Nevada received approximately \$295,000 in federal funds for the program. A staff of four processed reports and applications. Because of financial limitations, only a fraction of those who might benefit from the program are served; 1642 children were served in 1970.²⁰ Some of those unserved by CCS were nonambulatory, physically handicapped, mentally retarded residents of the Nevada Mental Health Institute, according to administrative personnel there.²¹ To the extent that they are able to pay, parents are responsible for the costs of their child's medical treatment.

EASTER SEAL TREATMENT CENTERS

The Easter Seal Society operates two centers in Reno and Las Vegas that provide physical therapy and speech therapy to multiple handicapped mentally retarded and other handicapped Nevadans.²² With a 1974 direct service budget of \$191,933, the Society provided 5291 physical therapy treatments to 276 Nevadans, and 7786 speech therapy treatments to 508 Nevadans. Included in the above totals were services under a \$17,000 Developmental Disabilities program to provide a traveling physical therapist to serve 58 retarded people in Community Training Centers throughout the state, and a contract to serve some children in the Helen J. Stewart School for mentally retarded children within the Clark County School District. The traveling physical therapist program has been discontinued because of the feeling that the high travel time, in relation to the low service time and the few people served, did not allow effective use of the limited physical therapy staff available.

Clients are charged up to \$10 per treatment on a sliding scale of ability to pay; many clients pay nothing. Clients are referred from numerous sources, including the two sources noted above, the Special Children's Clinic (6 in 1974), the Bureau of Vocational Rehabilitation (6), and the Crippled Children's Services program (about 36). In December 1974, the Reno clientele included 14 retarded people of 37 in physical therapy, and 18 retarded people of 36 in speech therapy. The comparable figures for Las Vegas were 38 of 67 in physical therapy and 5 of 42 in speech therapy.

²⁰ See U.S. Department of Health, Education, and Welfare, *Children Who Received Physician's Services Under the Crippled Children's Program, FY 1970*, MCHS Statistical Series No. 3, December 1971, p. 14.

²¹ Interview with D. Davis and D. Edwards, Mental Retardation Section, NMHI, Sparks, Nevada, August 1974.

²² Interview with R. Junius, Easter Seal Society, Las Vegas, Nevada, January 6, 1975.

The Reno staff included one physical therapist and two speech therapists, the Las Vegas staff two physical therapists and one speech therapist.

The society serves people aged 5 and upward in its centers. It also offers a program that combines infant stimulation and parent training for children aged 0 to 4 whose development is delayed. The program consists of 12 one-hour physical therapy treatment sessions involving parents and the child, plus 18 one-hour consultation and training sessions to teach the parents how to help the child.

The Easter Seal Society is thus a source of physical and speech therapy for mentally retarded and other handicapped people, supplementing the inadequate amount of those services available directly from government programs. In some cases the society provides those services on a paid basis as a vendor to the government programs, and in other cases provides them free or at low cost to clients referred by the government programs.

RECOMMENDATIONS

Currently, people in Nevada have three recourses in paying for mental health services, and for medical services for all types of mentally handicapped people: (1) privately financed care for those who can afford it or who have health insurance that covers needed services; (2) programs that receive payment from public funds, such as Medicaid, Medicare, and Crippled Children's Services for low-income people who cannot afford good care, and for others who qualify; and (3) publicly financed direct service programs (sometimes with charges to families of clients who can afford it) such as the Mental Health Centers and Mental Retardation Centers. On the whole, this three-part system can be readily defended, but certain aspects of the way it has been implemented need improvement.

Private health insurance often either excludes mental health coverage or offers more limited coverage for mental health than for physical health problems. The 1975 session of the Nevada Legislature extended coverage of alcohol and drug abuse treatment by making it mandatory for private health insurance to provide at least a specified minimum amount of coverage for alcohol and drug abuse treatment. We recommend that a study be conducted of the costs and benefits of requiring a mandatory minimum level of coverage for mental health and mental retardation services in every private health insurance policy. Potential effects of requiring such coverage include somewhat higher insurance costs,²² some decrease in the number of people purchasing health insurance because of the higher cost, increased quality-of-life benefits resulting from the increased provision of needed mental health and mental retardation services, and decreased government expenditures for services that are newly covered by private insurance. Before implementing a mandatory coverage requirement, those potential effects require careful examination as a function of the different minimum levels of mandatory coverage being considered and the types of mental disorders and services to be covered.

²² The cost implications and methods of cost control must be considered carefully, since altering insurance provisions alters the incentives of individuals to seek, or avoid the need for, services that are covered by insurance. See R. C. Auger and V. P. Goldberg, "Prepaid Health Plans and Moral Hazard," *Public Policy*, Vol. 22, No. 3, 1974, pp. 353 ff., or M. V. Pauly, "Overinsurance and Public Provision of Insurance: Roles of Moral Hazard and Adverse Selection," *Quarterly Journal of Economics*, Vol. 88, No. 1, 1974, pp. 44 ff.

With respect to publicly financed health insurance programs, the nonwelfare poor population (those who are medically but not categorically needy and hence not eligible for income assistance—see Chap. 14) are in worse shape with respect to financial access to medical services than are those who can afford private care and those who are on income assistance and hence eligible for Medicaid. County welfare offices sometimes meet the medical needs of the nonwelfare poor, but exclude most mental health needs because of strained county resources. The offices refer applicants to other public agencies. A look at the larger counties places county welfare mental health services in perspective. In Washoe County, the welfare office assumes responsibility only for psychotropic drugs. Clark County welfare pays for both drugs and hospital costs at Southern Nevada Memorial Hospital, but physicians must donate their services.

To remedy this situation, the Nevada legislative subcommittee for the study of the consolidation of state and local welfare programs has recommended that "...the legislature take action in 1975 to expand the SAMI [Medicaid] program to include the group known as the 'medically needy.'"²⁴ If SAMI were expanded to meet the federal definition of "medically needy," financial eligibility would be limited to those having an income below 133 1/3 percent of the Aid to Dependent Children grant level, after deducting medical expenses. That expansion would not necessarily include everyone who now receives county medical assistance. If the expansion were authorized, however, the state could obtain 50 percent federal matching funds. Those funds not being available to the county now, it must operate its own medically needy program with 100 percent county funding, in addition to paying an annual ad valorem tax levy of 11 cents per \$100 assessed valuation to help support the state's SAMI program.

Concerning ADC, yet another point bears consideration. As determined by the State Welfare Board, ADC payments are currently 70 percent of the full standard of need in Nevada (see Chap. 14). Anyone earning between 70 percent of his need and full standard (i.e., earning between \$230 and \$329 a month for a family of four) is deprived not only of income assistance but of Medicaid benefits.

Finally, with respect to publicly operated direct service programs, such as the state mental health centers and mental retardation centers, neither public nor private health insurance programs have been fully tapped in the past to pay for those direct services. The Reno Mental Health Center, for example, only recently began charging clients on a sliding fee schedule geared to ability to pay. A recent audit of the Las Vegas Mental Health Center revealed it had never tried to collect Medicaid benefits for services to Medicaid-eligible clients.²⁵ The Nevada Mental Health Institute currently supplements its program by billings to private insurance companies. Revenues amounting to about \$225,000 a year are required to be collected and expended as a portion of the overall authorized budget. The Medicare and Medicaid programs are also billed for NMHI residents covered under either of those programs.²⁶ By billing for service to those persons who have the means to pay (e.g., those on Medicaid or with private insurance), state-operated program monies will

²⁴ Legislative Council Bureau, *Final Report*.

²⁵ As reported in "Homeless Children Not Orphans—Not Wanted," *Las Vegas Review Journal*, August 1, 1976, Part 1, p. 4.

²⁶ Letter from T. Piepmeyer, Nevada Mental Health Institute, Sparks, Nevada, to J. S. Kakalik, The Rand Corporation, Santa Monica, California, February 27, 1976.

be supplemented, allowing for provision of more services. We recommend supplementing state monies by billing private and public health insurance programs to the maximum extent feasible to pay for state-operated direct service programs for mentally handicapped Nevadans. Personnel of the Nevada Division of Mental Hygiene and Mental Retardation have taken steps in that direction recently and we endorse their efforts. It does not make good fiscal sense from the viewpoint of the state as a whole to spend a dollar for service through the budget of the Division of Mental Hygiene and Mental Retardation when the same service can be funded through the Medicaid budget of the Nevada Welfare Division at a cost of 50 cents to Nevada and 50 cents to the Federal Government.

We noted earlier that the Medicaid program does not provide the same coverage for all age groups in the mentally handicapped population. One effort to modify this differential coverage is embodied in the federal Social Security Amendments of 1972 (P.L. 92-603), which authorize matching federal funds for care in psychiatric hospitals for Medicaid beneficiaries under 21 years of age, if certain requirements for patient evaluation are met. We suggest that Nevada consider exercising its option of matching the 50-percent federal contribution in providing for the mental health needs of its youth. Currently, many youngsters in need of residential mental health care are unserved or have been made wards of the state and been sent to out-of-state institutions, with the Nevada Welfare Division bearing the total cost (see Chap. 10).

Chapter 13

RESIDENTIAL LIVING

INTRODUCTION

Meeting the diverse needs of mentally handicapped people requires a wide range of residential programs, suited to the various levels of individual functioning and service needs. These programs vary from full inpatient care facilities for people who have acute mental health problems or who are nonambulatory and profoundly mentally retarded, through less-service-intensive intermediate care facilities, through semi-independent residential living programs that offer minimal supervision and assistance.

In Chaps. 9 and 10 we discussed mental health, mental retardation, and alcohol and drug abuse *residential treatment* programs intended to provide more than supervised residential living. This chapter focuses on programs that provide supervised *residential living* for people who are unable to live with their own families or to live independently in the community; these programs are not intended to and do not provide any other substantial mental health, mental retardation, or alcohol or drug abuse services.

Nevada's supervised residential living programs include foster homes for children, developmental homes for retarded children and young adults, adult group care and family care facilities, sheltered living apartments, the state children's homes, the state juvenile training centers, and the federal Stewart School for Indian children and youth. The latter three types of facilities have significant numbers of mentally impaired youth as residents, but are included in this discussion of supervised residential living programs because they provide no substantial mental health, mental retardation, or substance abuse services.

Data are not available on exactly how many mentally handicapped people are in some of these facilities, but adding the numbers for the facilities on which some information is available yields an estimate of at least 290 mentally handicapped residents, for whom the expenditures for supervised residential living were at least \$620,000 in 1974. Those numbers do not include estimates for nonwelfare clients of adult group care and family care facilities, or for residents of the state training centers, Spring Mountain, the Home of the Good Shepherd, or the Stewart School.

After a discussion of each of the above-listed residential living programs, we conclude with recommendations for improvement.

DEVELOPMENTAL HOMES

Several private homes located throughout the Reno, Las Vegas, and rural residential communities are used for sheltered or semi-independent living for mentally retarded people, primarily those who have no families or whose families are unwill-

ing or unable to provide homes for them.¹ The Northern and Southern Nevada Mental Retardation Centers and the Nevada Mental Health Institute, which operate the residential care and training programs described in Chap. 10, also supervise the developmental homes on a weekly basis.

Nearly all the mentally retarded people living in the private "developmental homes" in the community are former residents of the Nevada Mental Health Institute or the Mental Retardation Centers who have developed to a functional level that enables them to live outside, but are not yet able to live fully independently in the community. They have progressed into a much less dependent living environment, and a much less costly one.

In Reno in August 1974, 12 retarded people lived in five separate homes; one person lived in a single-child foster home setting, and the other 11 were in four different homes, each licensed for foster care of four or fewer people.² There are five developmental homes in the Las Vegas area.³ Four are like group foster homes for four or fewer mentally retarded residents each. The fifth developmental home has four retarded adults living together semi-independently without live-in foster parents; during the day they are employed in a sheltered workshop. The semi-independent living home, however, is next door to one of the other developmental homes with foster parents, so that assistance (e.g., with shopping) and supervision are nearby if needed. In mid-1974 there was one developmental home in rural Nevada. For the state as a whole, 22 developmental homes and regular foster homes with mentally retarded residents were known to the Nevada Division of Mental Hygiene and Mental Retardation.⁴

Each developmental home receives a fee of \$280 a month per mentally retarded resident (\$100 for room and board, \$120 for personal services, and \$60 for clothing, personal needs, transportation, and so forth). The fees are paid by a fund administered by the Division of Mental Hygiene and Mental Retardation; they are reimbursed, when possible, through charges on a sliding fee schedule to the families of the mentally retarded residents and through payments from the Supplementary Security Income (public assistance) program (see Chap. 14). In late 1974, developmental homes housed 30 mentally retarded people at an annual cost of just over \$100,000.⁵ At an annual cost of \$3360 per person (12 × \$280) plus the cost of the once-a-week supervisory visit by Mental Retardation Center personnel, these developmental homes cost much less than the approximately \$10,000 per year per person residential care and treatment programs at the Mental Retardation Centers (see Chap. 10).

There is no formal training program for all operators of the developmental homes, but some are former staff members of Mental Retardation Centers who

¹ For a discussion of residential living alternatives for retarded people, see President's Committee on Mental Retardation, *New Neighbors: The Retarded Citizen in Quest of a Home*, DHEW Publication No. (OHD)74-21004, Washington, D.C., 1974, and National Association for Retarded Citizens, *The Right to Choose: Achieving Residential Alternatives in the Community*, Arlington, Texas, October 1973.

² Interview with E. Pillard, Administrator, Northern Nevada Mental Retardation Center, Sparks, Nevada, August 21, 1974.

³ Interview with F. Cline, Clinic Administrator, Southern Nevada Mental Retardation Center, Las Vegas, Nevada, July 16, 1974.

⁴ Interview with J. Middleton, Associate Administrator for Mental Retardation, Division of Mental Hygiene and Mental Retardation, Reno, Nevada, August 5, 1975.

⁵ Governor M. O'Callaghan, State of Nevada, *The Executive Budget: Fiscal Years 1975-76 and 1976-77*, Carson City, Nevada, January 20, 1975 (hereafter cited as *The Executive Budget*).

should not need extensive new training, and others receive informal training on an ad hoc basis (e.g., by going to a Mental Retardation Center two hours a day for two weeks). Also, each home operator receives some specific instructions before a retarded person is placed, and occasional respite care is provided by the Mental Retardation Centers.

FOSTER HOMES

Mentally retarded and emotionally disturbed young people unable to live with their families can also be placed in regular foster homes with funds from the Nevada Welfare Division. Mentally handicapped people are a significant but not reliably known fraction of the approximately 365 in foster home placement (exclusive of institutions) in late 1974, at an average cost of about \$120 per month.⁶ Over one-third were thought by their Welfare Division case workers to be mentally retarded, brain-damaged, or emotionally disturbed, although these opinions of course are not confirmed diagnoses of mental disorder. As of March 1976, the Welfare Division had implemented a specialized foster home program with 15 homes for some of these children.⁷ Foster care expenditures for noninstitutional family care of these children who have been tentatively identified as mentally impaired amount to about \$175,000 per year. The total census of mentally retarded people at the Nevada Mental Health Institute was said to be rising slightly in mid-1974 because fewer foster homes were available and there were no funds to place those mentally retarded residents of the Institute who were capable of living in foster or developmental homes.⁸ The limitations on developmental home funds for retarded people not only keep some people institutionalized unnecessarily, but constitute false economy; institutional care in Nevada costs two to three times as much as developmental home care, and several times as much as foster home care. Meanwhile, the Child Welfare budget account of the Nevada Welfare Division, which pays for foster care, had a surplus of \$216,000 that was unspent in FY 1974.⁹

ADULT GROUP CARE AND FAMILY CARE FACILITIES

Nevada's adult group care and family care facilities, listed in Table 13.1, provide residential living services for adults who cannot or do not want to live in their own or their families' homes, but who do not need the more extensive services of intermediate care facilities, skilled nursing facilities, or hospitals (see Chap. 12 for a description of the latter three facilities).

For welfare recipients unable to care for themselves in their own homes, the Nevada Welfare Division provides adult services, i.e., placement and supervision, in a wide variety of facilities such as hospitals, skilled nursing homes, intermediate care facilities, adult group care facilities, and adult family care facilities. Of the 600

⁶ Ibid., p. 352.

⁷ Interview with Child Welfare personnel, Nevada Welfare Division, Carson City, Nevada, August 1974, and a letter from W. LaBadie, Nevada Welfare Division, to The Rand Corporation, March 3, 1976.

⁸ Interview with D. Davis and D. Edwards, Clinic Administrators of the Mental Retardation program at the Nevada Mental Health Institute, Sparks, Nevada, August 20, 1974.

⁹ The Executive Budget.

Table 13.1

**ADULT GROUP CARE AND FAMILY CARE FACILITIES
IN NEVADA**

Adult Group Care Facilities

Brendel Manor	Las Vegas
Monna's Manor	Las Vegas
Peaceful Acres Group Care Facility	Las Vegas
Rainbow Group Care Home #1	Las Vegas
Rainbow Group Care Home #2	Las Vegas
Van Buskirk Adult Group Care	Las Vegas
Camlu AGCF	Reno
Comer House	Reno
El Portal Boarding Home	Reno
Golden Age Gardens	Reno
Highland Manor	Reno
Mar Von #1	Reno
Mar Von #2	Reno
McBride's Golden Age Boarding Home	Reno
Montello Manor	Reno
River Haven	Reno
Sierra Homes, Inc.	Reno
Sierra Vista Homes	Reno
Twilight Home	Reno
Caliente AGCF	Caliente
Fallon Rest Home	Fallon
Golden Years Guest Home	Fallon

Family Care Homes

Loving's Family Care Home	Las Vegas
Moore's Family Care Home	Las Vegas
Pauline Jones Family Care Home	Las Vegas
Stewart Family Care	Las Vegas
Williamson Family Care	Las Vegas
Womack Family Care	Las Vegas
Barler Family Care Home	North Las Vegas
Gladys Culp Family Care #1	North Las Vegas
Gladys Culp Family Care #2	North Las Vegas
Ray Family Care Home	North Las Vegas
Singleton Family Care	North Las Vegas
Bris Family Care Home	Reno
Gwen Wood Family Care	Reno
Larremore House	Reno
Little Family Care Home	Reno
Sarli Family Care Home	Reno
Drakulich Family Care Home	Ely
Omtredes Family Care	Ely
Tognoni Family Care	Eureka
Pitta Family Care Home	Fallon
Josephine Lloyd Family Care	Pahrump
Ingle Family Care Home	Sparks
Stella Yates Family Care	Sparks
Zeta Family Care Home	Sparks
Supers Family Care	Carson City
Wilson Family Care Home	Boulder City

SOURCE: J. Fasching, Chief, Adult Services, Nevada
Welfare Division, Carson City, Nevada, August 1974.

adults placed in alternative living situations through the Welfare Division, about 90 persons had been diagnosed as psychotic, neurotic, or mentally retarded by a medical doctor or psychologist. Some 25 of these are in the Nevada Mental Health Institute. Another 200 persons are classified as senile.¹⁰ Data on what facilities these mentally impaired people are in, how long they have resided there, and their handicapping conditions are recorded but not yet analyzed by the Welfare Division and hence are unavailable to us.

The type of supervision the adult receives from the Welfare Division is up to the individual caseworker, who usually has a client load of 50 to 60 persons. Typically, more attention is paid to clients being prepared to return to their own homes. The Welfare Division's Chief of Adult Services believes that residents in adult group and family care facilities are provided a place to live, drugs if needed, and "nothing else" in the way of special services for any mental handicap if they have one.

The Welfare Division has data on its individual clients in these facilities, but because the data have not been aggregated we cannot even tell how many mentally impaired people there are in adult group care and family care facilities. And no one knows how many people with mental handicaps who are not on welfare reside in these various facilities, or whether they are receiving appropriate services.

SHELTERED APARTMENT LIVING

Both the Opportunity Village Association for Retarded Citizens in Las Vegas and the Washoe ARC in Reno operate small, sheltered living facilities for mentally retarded adults.

The sheltered apartments operated by Opportunity Village had 17 mildly or moderately mentally retarded residents in July 1974.¹¹ A family in one of the apartments in the building, which is in a pleasant residential neighborhood, provides minimum supervision. Each mentally retarded resident is assigned an OVARC counselor. Some of the residents work in regular jobs; others work in the OVARC sheltered workshop. The apartment rent, including utilities, is \$70 a month per person for a shared apartment and \$100 a month for a private apartment.

The sheltered living facility operated by the Washoe ARC provides not only semi-independent supervised living, but also some training in cooking and other skills needed as preparation for fully independent living elsewhere in the community. The 10 retarded residents are supervised by two live-in WARC employees. The intent is to make this a transitional facility where a retarded person can live for perhaps 6 to 18 months while developing independent-living skills. Residents must be employed either in the community or in the WARC workshop.

YOUTH SERVICES AGENCY AND RELATED PROGRAMS

In 1973 the Nevada Legislature created the Youth Services Agency, a Division

¹⁰ Interview with James Faehling, Chief of Adult Services, Nevada Welfare Division, Carson City, Nevada, August 1974.

¹¹ Interview with Dr. T. Johnson, OVARC, Las Vegas, Nevada, July 17, 1974.

of the Nevada Department of Human Resources, "to provide services for youth who are in need of residential care or in need of treatment or both."¹⁸ Of the six major residential facilities providing services for dependent neglected or juvenile delinquent youth in the state, four were placed directly under the auspices of this newly created division: the Northern Nevada and the Southern Nevada Children's Home (for adjudicated dependent neglected children), and the Nevada Youth Training Center and the Nevada Girls' Training Center (for adjudicated juvenile delinquents). The two additional major residential facilities serving adjudicated delinquent youth, Spring Mountain Youth Camp and the Home of the Good Shepherd in Clark County, are subsidized but not directly operated by the Youth Services Agency. In addition, a Juvenile Community Services program was created within the agency to reduce commitments for juvenile delinquency by having counties improve their services to potential juvenile offenders.

Although these programs are not primarily concerned with serving mentally handicapped youth, some mentally retarded and many emotionally disturbed children are undoubtedly placed in the above-named facilities for residential care. Stated another way, of the children who come under the purview of the Youth Services Agency, some are already emotionally disturbed, some may have been placed under the auspices of the Youth Services Agency because they come from very emotionally disturbing situations (e.g., abandoned, neglected, and physically abused children), and yet others may be placed in potentially emotionally disturbing situations (e.g., a child who commits a noncriminal act, yet is an adjudicated juvenile delinquent and sent to a state training center). Since some of the youth receiving residential care in these facilities have mental problems, the question is what is being provided in the way of services specifically addressing those mental problems. Also, as Bruno Bettelheim has pointed out:

More and more it has been recognized that not being able to live with his family is a considerable emotional insult to the child, no matter why it is necessary. It is felt, and for good reasons, that a child without parents is in as much need of therapeutic help—though his disturbance is usually much less severe, and more likely to be reversible—as the child who cannot live with his family because of the severity of his emotional disturbance.¹⁹

In this section, we first describe the physical facilities, the population served, and the mental health services offered in the residential care facilities by the Youth Services Agency. Since some of the population that could be served in residential care facilities by the Youth Services Agency are diverted to other service agencies, these decisions will also be described in this section.

The Children's Homes

When first established in 1870, the Northern Nevada Children's Home (then known as the Nevada State Children's Home) was restricted to orphans and half-orphans. Over the years, the population has shifted, and the two state children's homes are now for adjudicated dependent neglected children.

The Northern Nevada Children's Home (in Carson City) has seven filled-to-

¹⁸ Nevada Revised Statutes, 232.400-232.500.

¹⁹ Bruno Bettelheim, *A Home for the Heart*, Alfred A. Knopf, New York, 1974, p. 60.

capacity cottages, each housing ten children and their surrogate parents, cottage couples. In 1967, the Nevada Legislature appropriated funds for construction of two cottages for ten children each, to be called the Southern Nevada Children's Home (in Boulder City). Because these cottages quickly filled to capacity, additional funds were appropriated in 1971 to build five more to house an additional 50 children. Currently, these cottages are also filled. The FY 1974 expenditures for both homes combined were \$659,000.

Admission to either children's home is by court order only; recommendations for commitment are made to the court by the various referring agencies: state and county welfare departments, and probation and parole departments. Legally, the upper boundary for admission is 18 years of age. The Welfare Board, the policy board for the homes, established the lower age limit as five years old. As reported to us by the superintendents, most children admitted are well into their teens, with a history of problems behind them. Typically, they are not orphans. They need a home because of repeated failures to adapt to living in foster homes, recurrent running away from home, or incorrigibility.

The superintendent can refuse admission to a child if all beds are filled or if the public school cannot accommodate the child. Differences between the public school systems in Carson City and Boulder City account for some differences among the populations of the homes.

The Southern Nevada Children's Home typically excludes mentally retarded and severely emotionally disturbed children, and other children who need services not available in the Boulder City community. In addition, "if a child cannot make it in public school," he or she cannot remain at the Southern Nevada Children's Home. The lack of bed space was the only reason cited for excluding a child from the Northern Nevada Children's Home.

In the summer of 1974, the Northern and Southern Nevada Children's Homes had waiting lists of 50 and 11, respectively. These numbers may not reflect the true extent of those waiting for placement, since referring agencies aware of the backlog may curtail their referrals. The relative sizes of the waiting lists at the two homes reflect, in part, differences in their admission policies.

Most children at the Southern Nevada Children's Home come from Clark County. The Northern Nevada Children's Home draws most of its population from Washoe and rural counties, although they also serve a number of Clark County children because of the differences in admission policy.

Although some children are eventually returned to their families, for many the Children's Home will be their permanent residence until their 18th birthday. The average stay is two to three years, reflecting the late age at which most children enter the homes.

In outline form, the two children's homes offer approximately the same services. Each cottage of ten children is under the supervision of a cottage couple, surrogate parents. All children attend public school during the day; tutors are available in the evening since the majority of children at both homes are typically below their grade levels in school work. Each home has a staff of two social workers responsible for (1) determining if and when a child can be returned to the family, and (2) working with other agencies, either to obtain services or to refer the child to the agency. Each home nominally has psychological services available from other service agencies. Details of the differences in services are presented below.

Southern Nevada Children's Home.¹⁴ For each home, cottage couples are cruited by the state personnel system, which requires them to be high school graduates and to have been in charge of running a household with children for at least two years. From this group, both superintendents choose those persons who seem most able to provide a stable home for ten children. In addition, cottage couples at the Southern Nevada Children's Home are required to take a parent-effectiveness training course, most recently offered by the Cooperative Extension Service of the University of Nevada).

The home has the services of a paraprofessional mental health technician from the Henderson Mental Health Center for half a day each week. Within this time, he consults with staff about specific problems that the children may be having, but there is *almost no direct service* to the children. In addition, a school psychologist visits the home once every few months. Mentally retarded children and severely emotionally disturbed children usually are not admitted to the Southern Nevada Children's Home. Because of this policy, the superintendent of the home felt that the children under his supervision were in no further need of psychological services.

Northern Nevada Children's Home.¹⁵ Over the past few years there has been a dramatic change in the types of children who enter the Northern Nevada Children's Home. Instead of younger children who have been neglected, abused, or abandoned by their parents, recent admissions are older¹⁶ and have thus far been unplaceable or not successfully placeable in other facilities. For example, one child had had 18 foster home placements before acceptance at the Children's Home. (Although this is an extreme case, multiple placements of the same child in a series of foster homes are not unusual in Nevada and elsewhere.) According to the Superintendent of the Northern Nevada Children's Home, an unintended effect of not having a program for emotionally disturbed youth at the Nevada Mental Health Institute has been to shift responsibility for the residential care of some of these mentally handicapped children to the Children's Home. But the Children's Home does not have the budget, staff, or service program to provide residential mental health treatment.

At one time, the Northern Nevada Children's Home had the services, 1½ to 2 days a week, of an M.A.-level psychologist from the Carson City Rural Clinics office. From a waiting list of children, he would individually counsel those he had time to see. However, as of mid-1974, because of increasing community demand, the Carson City Rural Clinic no longer provided that service to the Children's Home.

As part of the residential program, all children are examined by a local pediatrician. As a result of his examination, a little less than half of the children have been placed on medication that, according to the superintendent, "allows the Home to work with the kid."

The Carson City schools have a school psychologist who maintains close ties with the Northern Nevada Children's Home. At the home's once-a-week staff meeting, two or three cases are discussed; present are Children's Home staff, the school

¹⁴ Interview with J. Gardner, Superintendent of the Southern Nevada Children's Home, Boulder City, Nevada, March 1974.

¹⁵ Interview with J. Aberasturi, Superintendent of the Northern Nevada Children's Home, May 9, 1974.

¹⁶ In the summer of 1974, the group of 70 children had only one 3-year-old and one 10-year-old. The other children were all older; the average age was 14.

psychologist, the principal of the school where the child is placed, and, when possible, the court liaison person, typically a welfare worker or probation officer.

Residential Centers for Juvenile Delinquents

Of Nevada's four major residential facilities for adjudicated delinquents, two are operated by the Nevada Division of Youth Services: the Nevada Girls' Training Center and the Nevada Youth Training Center. Although not under the jurisdiction of the Youth Services Agency, Spring Mountain Youth Camp and the Home of the Good Shepherd provide such similar services, and within certain dimensions interact so closely with the training centers, that they are also described within this section.

A separate budget account, called "Boys' School—Girls' School Reserves" and administered by the Office of the Director of the Nevada Department of Human Resources, provides not only reserved funds for expansion of the two training centers, but also funds for "Outside Agency Care" for "severely disturbed boys and girls who are in need of the resources of a psychiatric program."¹⁷ About \$87,000 was expended for that Outside Agency Care in FY 1974 (about \$79,000 for boys and \$8,000 for girls).¹⁸

Nevada Girls' Training Center.¹⁹ Located at Caliente, the Nevada Girls' Training Center has five cottages of 20 beds each, and expended \$875,000 in FY 1974, not including the cost of parole counselors. Although originally built for 100 girls, the number of girls in residence sometimes exceeds the facility's capacity,²⁰ but the average number of residents in FY 1974 was 80. Although the legal age for commitment can be 8 to 18 years old, the youngest child so far was an 11-year old. As is true for all adjudicated delinquents in Nevada, the length of commitment is indefinite, averaging 9.2 months at Caliente.

A crime for an adult is a delinquent act for a minor, but children are also adjudicated delinquent for actions that are not crimes for adults: running away from home, truancy, and unmanageability, a catchall term that can include such offenses as smoking, promiscuity (for girls), and disrespectfulness. In May 1974, the superintendent reported that only 12 girls at Caliente had committed crimes in the adult sense of that word: sale of drugs (2), burglary (8), larceny (1), and auto theft (1).

Upon arrival at the training center, the girl is placed in an intake cottage for a two-week evaluation by a psychologist (hired in January 1974), a classification counselor (M.A. in psychology), and a school counselor.

While at Caliente, the girls attend school on the training center premises. After school, the girls meet with their group counselor, their academic staff, and their parole counselor—if available—in a group counseling session. It mostly consists of "rapping" with facility personnel about personal and interpersonal problems.

Youth parole counselors have the responsibility of working with the juvenile delinquent and her family. The budget for these counselors for girls was \$129,000 in FY 1974. According to the Superintendent of the Nevada Girls' Training Center,

¹⁷ *The Executive Budget.*

¹⁸ *Ibid.*

¹⁹ Interview with J. Miller, Superintendent, Nevada Girls' Training Center, Caliente, Nevada, May 6, 1974.

²⁰ In May 1974, the training center had a population of 106.

the parole counselor visits each of approximately 15 girls assigned to him once a month and visits her parents at least once every two weeks. He has the responsibility of counseling the girl and her parents, recommending the length of parole after release from the training center (average time, 11.2 months), and helping to decide whether a girl should be returned to her family or placed in a foster home.

For these responsibilities, a youth parole counselor must have a bachelor's degree or three years of experience in the field. Training for the parole counselors was sought from the Rural Clinics program operated by the Division of Mental Hygiene and Mental Retardation, but according to the superintendent, "We couldn't get it." The training center then turned to the Las Vegas Mental Health Center, which reportedly provided some "behavior modification" training for the parole counselors.

Nevada Youth Training Center.³¹ The Nevada Youth Training Center for adjudicated delinquent males is located about three miles east of Elko, and had FY 1974 expenditures of \$1.23 million, exclusive of the cost of parole counselors. The facility can house 180 boys, the average caseload being 142. Their average age is 16.5 years, but boys as young as 11 have been sent to Elko. Unlike the girls' training center, many of the boys have been committed for acts that are crimes for adults (ranging from relatively minor misdemeanors up to murder).

All boys are held for at least six months; average length of stay is 7.5 months. Each boy is sent to the training center for an indefinite period of time. Release depends upon meeting the behavioral and academic goals established for him during his intake period. An M.A.-level classification counselor has chief responsibility for the testing and goal-setting.

When the boys first arrive, they are tested for several weeks to determine their dorm groupings. Dorm groupings, which also form school class groupings, are determined by size, age, and emotional maturity. An as-yet-unaccredited school is located on the premises. Although some of the younger children attend school all day, most of the children spend half the day in class, and half the day in vocational education, which consists of such activities as woodshop and meat-cutting.

Youth Parole Counselors provide services before and following discharge similar to those reported for the Caliente facility; the budget for the counselors in FY 1974 was about \$220,000. However, no inservice training was reported. If the family situation is not "adequate" at the time of the boy's release, the center may make placements in the Army, Job Corps, or one of two group homes.

In effect, no psychiatric services are available for the children at the Elko facility. According to the Assistant Superintendent of the Nevada Youth Training Center, no services have been provided by the Rural Clinics mental health program, although their services have been requested. The staff described some of the boys as possibly psychotic and others as hyperkinetic; they were thought by the staff to be in need of drugs that the once-a-week visiting doctor is unwilling to prescribe because he does not feel qualified to make a psychiatric diagnosis. The assistant superintendent said that he "could use at least a once-a-month visit by a psychiatrist."

³¹ Interview with C. Stewart, Superintendent, Nevada Youth Training Center, Elko, Nevada, April 1974.

Residential Alternatives to the Training Centers

Adjudicated delinquents also may be sent to one of two Las Vegas facilities, the Home of the Good Shepherd (for women) or the Spring Mountain Youth Camp (for men). These institutions take the "less hardened delinquent." If the child cannot adjust to the program, he or she is then sent to a training center.

Home of the Good Shepherd.²² This Las Vegas facility is under the direct management of the Sisters of the Good Shepherd. The home has enough capacity for about 60 adjudicated delinquent girls, 12 to 17 years of age, from counties throughout Nevada. The average FY 1974 monthly census was 49. The sisters decide whether the home will admit the girl by interviewing both her and her family, and advise the probation officer whether he should recommend to the judge that the girl be sent to Las Vegas rather than Caliente. For each court-committed girl, the home receives \$300 a month from state funds; the FY 1974 total state expenditures were \$163,000. The home also has a strong auxiliary for fund-raising and they receive many private donations. Average length of stay is 9 to 12 months; parole usually extends 3 months.

The home runs its own school. Several of their teaching staff members are professionally trained in psychology or social work. Fifty-five minutes of group therapy is required daily for each girl, and individual therapy with the staff is available. The home also offers counseling to the girls' parents, but the Mother Superior says that most parents refuse to cooperate.

In 1973-1974, the Home of the Good Shepherd established a "prevention program" that provides day care to 17 pre-delinquent girls. This program includes schooling and meals, at a cost to parents of \$50 a month. The Mother Superior estimated that 100 girls would be enrolled in the program in 1975.

Because of the lack of community facilities for girls whose home situations were such that they could not return to their families, the Home of the Good Shepherd opened a group home (referred to as a "community educational center") in Clark County for four girls in 1973. In summer 1974, they opened a second center in Clark County for eight girls.

Spring Mountain Youth Camp.²³ This residential facility for adjudicated delinquents is maintained and operated by Clark County for its residents. Isolated from the community by its mountain location, it was established for "less hardened delinquents"; the age range is 13 to 18 years. The camp provides an open forestry camp setting without constant direct supervision. If the boy is not hardy enough for this outdoor life, if the other boys pick on him too much, or if in some other way he does not fit into or respond to the program, he usually is sent to Elko.

The camp has enough capacity for 80 boys; the monthly census in 1974 ran from 56 up to capacity. The delinquent boys attend school at the camp, but can go home on weekends. Sentences are indeterminate, with the average stay being six months. The state pays \$250 a month per resident (\$135,000 in FY 1974); the county pays the remainder of the costs.

If the boys have psychological problems, we were told they are referred to the Las Vegas Mental Health Center or the Children's Behavioral Services program.

²² Interview at the Home of the Good Shepherd, Las Vegas, Nevada, July 16, 1974.

²³ Interview at the Spring Mountain Youth Camp, Clark County, Nevada, July 1974.

Juvenile Community Services Program

Created by the 1973 Nevada Legislature, the Juvenile Community Services program ²⁴ within the Youth Services Agency was mandated to "develop and assist in the implementation of programs for the diversion of juveniles out of the judicial system and programs for the aftercare of juveniles who have been released from state institutions or who have been brought before juvenile court or have otherwise come into contact with law enforcement agencies."²⁵ In FY 1974, \$376,000 in juvenile probation subsidies went from the state to Juvenile Court Services programs in the various judicial districts.

Juvenile Court Services

Juvenile Court Services personnel often process emotionally disturbed children who are candidates for various residential care programs. Abandoned, neglected children, "Children in Need of Supervision (CHINS),"²⁶ and children accused of committing criminal acts can come within their purview. The different systems of juvenile court services in the Las Vegas and Reno areas are summarized below.

Clark County Juvenile Court Services.²⁷ The Clark County Juvenile Court Services program has two major divisions: one for abandoned, neglected children and CHINS, and the other for delinquents. When first brought to the attention of Juvenile Court Services, the first category of children are interviewed by one of two M.A.-level psychologists, and tested by a B.A.-level psychometrist. Referrals may then be made to various community resources (e.g., depending on the child's age and the catchment area in which the child lives, the Henderson Mental Health Center, the Las Vegas Mental Health Center, or Children's Behavioral Services). It can also be decided by the probation officer or protective services officer assigned to the child that he or she should not be returned home. When that happens, the child is made a ward of the court, which may, for example, send the child to one of the two children's homes or turn the child over to the Nevada Welfare Division for foster home placement. While these decisions and arrangements are being made, the child is housed in Child Haven, a temporary holding facility.

Delinquents are processed somewhat differently. The child is detained in David Zenoff Hall, a temporary holding facility, until a decision is made about his future program. Some children leave the system after intake (an interview with the child and his parents). For children aged 14 and over charged with capital offenses, and children 16 and over charged with felonies, the cases go to the district attorney, who decides whether a youth should be tried as a juvenile or as an adult. Children appearing before a juvenile judge may be handled in the community using the probation subsidy funds noted above, or be sent to a residential institution. Before the judge makes a disposition, the child is interviewed by a court psychologist and tested by the psychometrist; the resulting information is available to the judge.

²⁴ Interview with Wayne Bartels, Deputy Administrator, Juvenile Community Services Division of the Youth Services Agency, 1974.

²⁵ Nevada Revised Statutes, 232.470.

²⁶ For noncriminal acts (e.g., truancy, incorrigibility) the court first declares the child a CHINS; if the child violates his or her CHINS agreement, the child can then be labelled delinquent and sent to a training center.

²⁷ Interview with N. Solomon, Clark County Juvenile Court Services, Las Vegas, Nevada, 1974.

With the advent of the probation subsidy for juvenile community services, judges have more dispositional alternatives. This money has allowed Clark County to provide alternatives to residential care in state training centers. The alternatives include professional parent homes (seven possible placements in 1974); Ettie Lee Home for Boys, Inc. (six bedspaces purchased for \$300 per bedspace per month); and Regina Hall (six bedspaces purchased for \$275 per bedspace per month). All these alternative living places are continuously filled. In addition, subsidy money has established a "Recycling Plan" (for vocational training), a Day Care Coping Center (for girls), tutoring programs, and intensive counseling and supervision. The Coping Center is for girls on the probation subsidy program to go to when they are not in school; cooking, sewing, and hygiene lessons are available, as well as educational and vocational counseling. The intensive counseling and supervision program consists of teams composed of probation officers, paraprofessionals, volunteers, off-duty police, and persons in training to become probation officers. All have received some amount of in-service training to work with delinquents; none are mental health professionals trained to work with emotionally disturbed children. The same sort of counseling is available for children residing in alternative living quarters. No direct services are provided by the two court psychologists.

Children who cannot "make it" in the probation subsidy program are sent to a state training center for residential care; this latter situation held true for eight percent of those involved in the Clark County probation subsidy program for FY 1973.

Washoe County Juvenile Services.²² In Washoe County, the Probation Department is responsible for children accused of delinquent acts; the County Welfare Department has a child welfare program for abandoned and neglected children, and for abused children. Since the term "delinquency" covers so wide a variety of behaviors (from incorrigibility to murder), probation and welfare personnel sometimes must consult about who has responsibility for some children. If the child has committed any kind of criminal act, welfare personnel abjure responsibility.

For neglected dependent children, county welfare personnel will attempt to keep the child in the home by working with the parents. If the situation appears hopeless, they will either initiate court action to remove the child from home, or refer to another agency. Abused children are placed in foster homes. The county child welfare staff consists of four social workers, plus a supervisor with a partial load; social workers typically have 60 to 80 cases each. The County Welfare Department has set aside a small budget for institutional care in case the courts ever give them this responsibility. There is a statute on the books, however, (NRS 432.020 (b)), which the county believes assigns the responsibility for handicapped children to the state Welfare Division; consequently, the county has taken the state Welfare Division to court on more than one occasion to force them to assume that responsibility.

As in Clark County, the Probation Department has responsibility for a number of mentally retarded and emotionally disturbed children who are part of the regular probation caseload. Probation subsidy dollars have allowed the creation of two programs: the Multi-Discipline Assistance Program (MAP) and the Intensive Treatment Unit.

The MAP program, which is open to children from the northern rural counties

²² Interviews with staff of Washoe County Welfare, and F. Sullivan, Juvenile Probation, Reno, Nevada, 1974.

as well as Washoe County, uses a coordinated team of medical, dental, and psychological²² professionals to diagnose "youngsters who are particularly 'baffling' to you regarding the cause of their delinquent behavior—where there doesn't appear to be any reason—who are not performing up to their potential."²³ No fee is charged for housing or the other services rendered. These children can either be wards of the court or in some stage of the juvenile court process.

The Multi-Discipline Assistance Program accepted its first child in February 1974. Between February and June 30, 1974, a total of 42 children were evaluated, about half from Washoe County. The program identified three hyperactive youths, 20 with below average I.Q., and two severely retarded youth. All 42 were said to have behavior problems, the most prevalent of which (11 youths) were due to a "combination of parent rejection and child acting out feelings of rejection, distrust, and conflict."²⁴ One was reported to have a "severe emotional instability." However, we note that the MAP program is only for diagnostics for youth aged 12 to 18 years. The follow-up program is weak because of the extremely limited mental health services available for juveniles in Washoe County (see Chaps. 8 and 10 for details), and because the Probation Department feels it cannot afford the \$15 per day per child charged them by the Reno Mental Health Center for the few children the center will accept.

The Intensive Treatment Unit is operated directly by the Probation Department. Its staff consists of two juvenile-peer staff members and three probation officers. It offers intensive supervision to children who would otherwise be institutionalized in the state training centers.

STEWART SCHOOL²⁵

The Stewart School, outside Carson City, has a 560-bed residential program for Indian children. Typically, between 460 and 500 are enrolled. The school provides a classic example of recognizing a need for services that are not available in the local community and building an institution to meet these needs—but providing only a minimal program of services in the institution. Run by the federal Bureau of Indian Affairs,²⁶ the Stewart School provides a residential program during the academic year for Indian children who do not have, or cannot be served adequately in, school facilities in their local area, are educationally retarded (i.e., are significantly below the expected grade level academically), or who need a residential program for any social reason justified by the courts, local welfare agency, or probation office. Thus, in practice, the Stewart School has many "problem" Indian children.

Children must be at least 14 years old to be sent to the Stewart School, and they can remain until they graduate. In the spring of 1974 no student over 20 years old

²² MAP buys the quarter-time services of a Ph.D. psychologist, who along with his other duties acts as a consultant to all cases under the purview of the Washoe Probation Department.

²³ From a brochure describing the MAP program, sent to the other counties invited to participate.

²⁴ Letter to Mr. Wayne Bartels, Nevada Youth Services Agency, from Frank Sullivan, Chief Probation Officer, Washoe County, Nevada, July 15, 1974.

²⁵ Information in this section is based on interviews at the Stewart School in the spring and fall of 1974.

²⁶ To be eligible for entrance, the federal requirement is that the student must have at least one-quarter Indian blood and be living on or near a reservation. For Nevada, that criterion effectively includes any Indian living in the state.

was enrolled. Children come to the Stewart School from the Western states: about 70 percent are from Arizona, 20 percent from Nevada (about 80 children) and 10 percent from California, Idaho, and Oregon.

The Federal Government furnishes resident students their room and board, tuition, books, and supplies. Students are expected to help pay for these services through a share-the-work program. Because spending-money is not provided, students are encouraged to find regular and part-time jobs.

The Stewart School has an unaccredited academic program with a weak vocational education component. Mentally retarded children are placed in one of two special education classes, which serve approximately 15 pupils each. The principal stated that he has 40 other students who need special education facilities. There are six vocational counselors.

The students at Stewart School are not court-committed and the principal has no legal jurisdiction over them. Although students can withdraw from school and return home at their option, they are not free to leave the school grounds while enrolled. There is a pass system by which students can leave either their classrooms or school grounds for stipulated amounts of time, depending upon how the school ranks their behavior.

According to the principal, 90 percent of the children at the school are there because of emotional and behavioral problems, and only 10 percent because of a lack of educational facilities in their local areas. Psychological counseling services are minimal for the 90 percent with emotional and behavior problems. The school has one M.A.-level psychologist who serves as consultant to the school staff on mental problems, carries a case load of approximately 30 students whom he sees individually on a weekly bases, and is chief administrator of the student infirmary.²⁴ In addition, the school has a budget of \$10,000 a year for a mental health consultant, who sees six or seven children a year for an average of 10 hours per child. In the fall of 1974, no Stewart School student was being administered behavior-controlling drugs, although chemotherapy has been used with several students in the past.

The Stewart School is an example of a federal residence primarily for problem Indian children—with little differentiation of services to resolve the problem (e.g., mental illness, mental retardation, abusive parents)—and little individualized treatment. For the most part, the children are sent to the Stewart School as if it were a residential treatment center. But the school responds to its 500 or so "problem" children as an academic institution; children exhibiting "behavioral problems" are expelled from school. In past years, as many as one-quarter of the enrolled pupils were expelled from school over the course of the school year at the request of either their academic teachers or dorm counselors.

In an attempt to partially remedy this peculiar situation (most of the children are there because of "problems," but if they present "problems" they are ejected), an awareness center is being established on campus with a grant of \$95,000 for two years (1974-1976) from the National Institute of Drug Abuse. This program, which currently consists of peer counseling, is in the process of being organized.

Because this is a federally operated program, there is little the state can do directly to improve services for these youth at the Stewart School. However, if the Nevada youth and their families live nearby and are willing to be served by educa-

²⁴ Interview with Mr. R. Willis, school psychologist, Stewart School, fall 1974.

tion, mental health, and mental retardation programs intended for the general Nevada population, then services might be improved by removing the youth from the Stewart School.

RECOMMENDATIONS

The developmental homes and sheltered living apartments, which permit mentally retarded residents to live in sheltered foster-home or semi-independent living situations in the private residential communities, are for those people who are not yet capable of fully independent living, but do not need the much more dependent and costly residential care and treatment programs provided by the Mental Retardation Centers and the Nevada Mental Health Institute. The major problem with these programs is their tiny size; only 30 people were served in developmental homes and only 27 in sheltered living apartments in the entire state in late 1974. Prior to the existence of the developmental homes and the small sheltered living programs operated by the Opportunity Village and Washoe Associations for Retarded Citizens, the type of people now in these programs typically were served in the more institutionalized and much more expensive residential care programs or were not served at all by the mental retardation programs. *We recommend that the developmental home and sheltered living apartment programs at least double the number of people served.* Based on information gathered in our interviews, it appears that at least two to four times as many placements into these sheltered living programs could be made if they had the capacity. As more mentally retarded people with functional abilities appropriate to these programs are identified, and as the skills of people with lesser functional abilities are improved so they can be moved out of a more restrictive environment such as NMHI or one of the mental retardation centers, it is possible that the program could more than double in size. Creating more of these sheltered community living facilities would facilitate serving more people "in the least restrictive environment possible," which is one aspect of the state goal of the Nevada Division of Mental Hygiene and Mental Retardation (see Chap. 1). However, while these programs are good in theory, they can be subverted by poor implementation. We see potential problems in implementation in at least three areas that currently are handled on an ad hoc basis: facility and personnel standards for the homes and apartments; training of the staff; and supervision of the staff. *We recommend that facility and personnel standards and licensing be established specifically for private developmental homes and sheltered living apartments for retarded people, and that staff members receive specified levels of training.* At present, the only license required for a developmental home is that of a regular foster home. As the developmental home program grows, the present ad hoc selection and supervision of the homes and the lack of formal training of the operators by the Mental Retardation Centers should be supplemented by clear and enforceable minimum quality standards and by a staff training program. The same quality control measures should be adopted for the sheltered living apartments.

We recommend that all supervision of mentally retarded people living in private developmental homes in the community be the responsibility of the Mental Retardation Centers, rather than having it shared by the centers and the Nevada Mental Health Institute. To help ensure that necessary supervision is provided, to simplify

the bureaucracy, to help the developmental homes to function in a coordinated manner, to serve those most in need first, and to provide the most efficient and effective support for the operators living in or near the developmental homes, it would appear that undivided responsibility for this small program would be an improvement over the present situation, in which both the centers and the Institute are creating and monitoring developmental homes. To supervise rural county developmental homes, the Mental Retardation Centers might contract with a local rural special education teacher of retarded children.

While regular foster homes and adult group care and family care facilities currently are outside the domain of control of the mental health, mental retardation, and alcohol and drug abuse service system, it could only improve matters if those facilities that provide supervised residential living for people with these handicaps were subject to a few minimum facility standards and personnel selection and training standards, and received some supervision by state mental health, mental retardation, and alcohol and drug abuse personnel. These quality controls would help ensure supervised residential living of at least minimal quality for mentally handicapped people. *We recommend that special minimum standards and supervision be established for foster homes and adult group care and family care facilities that provide supervised residential living for people with mental health disorders, mental retardation, or alcohol or drug abuse problems.* Personnel with special expertise in serving mentally handicapped people should provide the supervision, just as the Mental Retardation Centers now do for the developmental homes. We caution that the purpose is to ensure at least minimally acceptable living conditions; care must be taken not to cause existing residential living facilities simply to reject all mentally handicapped applicants.

Of the children placed in foster homes by the Nevada Welfare Division, social workers suspect that more than one-third have mental problems. *We recommend referral of each mentally handicapped foster child to the Division of Mental Hygiene and Mental Retardation or to a Division of Health Special Children's Clinic for evaluation, followed by appropriate service by both those divisions and the local special education program if the presence of a mental disorder requiring service is confirmed.* The Regional Direction Centers we recommended in Chap. 4 could facilitate this process and provide needed diagnosis, referrals, and follow-up.

The Youth Services Agency facilities and related programs providing supervised residential living for children in the two state children's homes, the two state training centers, the Home of the Good Shepherd, and the Spring Mountain Youth Camp were not established to serve as mental retardation and mental health treatment centers. Many of the children receiving residential care in those facilities are emotionally disturbed, however, and some are mentally retarded. Some provision should be made to see that the mental health and mental retardation service system serves those children while they are in supervised residential care programs of the Youth Services Agency. Historical precedent, court and legislative decisions, geographic location near to or far from other service programs, lack of availability of residential treatment services for mentally handicapped youth in other facilities in the state, and the philosophy of the superintendent of the various Youth Services Agency and related facilities in Nevada, all are contributing factors in determining whether children with mental problems are admitted to those facilities, whether they remain unserved in these facilities, whether facility staff members who have

not been adequately trained to treat these children nonetheless attempt to do so, whether an adequate number of staff who are professionally qualified to treat mentally handicapped youth are hired, and whether the children are referred to other programs for mental health and mental retardation services. The Southern Nevada Children's Home superintendent and his staff are advised a half-day each week by a mental health technician from the Henderson Mental Health Center, but there are almost no direct psychological services to children because the superintendent believes the children he admits do not need them. Of the six residential programs described, five make use of or have attempted to obtain services from other mental health service programs. The Northern Nevada Children's Home and both training centers have tried and said they failed to obtain needed services from the Rural Clinics program. (See Chap. 8 for a discussion of that program's mental health services and unrealized potential.) The assistant superintendent of the Nevada Youth Training Center described boys who in his opinion should be at the Nevada Mental Health Institute rather than at Elko—but that the Institute is not utilized because it will not admit younger teenagers, and those few older teens it will admit are typically released in a few days without adequate follow-up services. The Elko facility had been unable to hire a psychologist at the time of our interview and the superintendent felt a great need to have a psychiatrist part-time to at least prescribe drugs for certain of the children who appear "hyperkinetic or psychotic." Available to the Northern Nevada Children's Home, on the other hand, is a pediatrician who has placed somewhat under half of their children on drugs; a main purpose of the drugs is to keep the children manageable.

There appear to be several reasons for the lack of delivery of mental health and mental retardation services to residents of these facilities: the facilities either have no mental health and mental retardation staff or do not have sufficient qualified staff; there appears to be considerable "buck-passing" on the part of other mental programs; and the capacity of other mental service programs in Caliente, Carson City, Elko, and Boulder City, where the four primary youth facilities are located, is not high (see Chaps. 8 and 10 for our discussions of the deficiencies of those programs and recommendations for their improvement). Most certainly, the rural location of the training centers has strongly affected the type of program they have been able to offer. Rurality denies them easy access to the specialized personnel, programs, and skills that are much more readily available in the urban centers' mental programs. Their remoteness also has made it difficult to recruit qualified staff. For example, both training centers have experienced great difficulty in recruiting psychologists. At the time of our interviews in May 1974, the Nevada Youth Training Center remained unable to fill the psychologist's position. Finally, the present fragmented service system lacks coordination in seeing that all different types of these children's needs are met (see our recommendations for Regional Direction Centers in Chap. 4).

To detect mental problems in youth, and to enable the provision of needed services, we recommend that all residents and referrals for residential care at the two Nevada Children's Homes and the two state training centers receive a professional psychological screening to identify potential mental health and mental retardation problems. Once mentally handicapped youth have been identified at these facilities, we recommend that the Division of Mental Hygiene and Mental Retardation be required to serve them, i.e., provide the appropriate level of services ranging from full residential treatment to day treatment to outpatient treatment. The primary

burden for mental health service probably would fall to the Rural Clinics outpatient mental health program, which in 1974 did not serve most children from these facilities, and which itself is only an embryonic program with major deficiencies that would have to be remedied before it could adequately carry this additional service burden. (See Chap. 8 for a discussion of those deficiencies, one of them being an inadequate number of staff.) If the Rural Clinics program is not to be improved, then some other mechanism for serving these mentally handicapped youth should be developed.

Chapter 14

INCOME ASSISTANCE

Three basic kinds of direct and indirect income assistance are germane to our discussion: direct cash transfers to help meet the financial needs of mentally handicapped people and their families; contributions to economic security through provision of human resources development services, such as special vocational education and vocational rehabilitation; and provision of services that do not contribute primarily and directly to economic security, such as medical care. This chapter considers only direct cash transfers; the other kinds were discussed in Chaps. 4 through 13.

Direct income assistance is available from the following sources in Nevada: federally funded Social Security Disability Insurance (SSDI), joint state and federally funded Supplemental Security Income (SSI), joint state and federally funded Aid to Dependent Children (ADC), and county funded General Assistance (GA). Only in the SSDI and SSI programs can a mentally handicapping condition be one basis for receiving direct financial aid.

The Nevada Welfare Division administers ADC, Medicaid (see Chap. 12), and social services for aged, blind, and disabled people who receive their income assistance checks directly from the Social Security Administration under the SSI program. County General Assistance provides income assistance for certain needy persons excluded from federal and state aid because they are unable to meet all eligibility requirements. This group includes persons who are (1) awaiting completion of processing of their SSI applications; (2) in need of emergency help; (3) members of intact families (both parents in the home); (4) temporarily unable to work but not technically disabled under SSI and SSDI regulations; and (5) who possess income and/or resources above the eligibility restrictions of other income assistance programs.

Both the state- and county-operated programs (ADC and GA, respectively) provide income maintenance to a defined population of financially needy people, some of whom also may happen to have mental handicaps. At least 1500 mentally handicapped Nevadans receive income assistance, which amounted to at least \$2 million in 1974 (see Table 14.1). Eligibility criteria for all programs are summarized below.

SOCIAL SECURITY DISABILITY INSURANCE

The federal Social Security Disability Insurance (SSDI) program is based on a social insurance model wherein both employee and employer, and self-employed persons, contribute to the system to provide coverage against disruption or reduction of the worker's income due to disability, death, or retirement. Disability is defined as a physical or mental condition that prevents a person from doing any substantial amount of gainful work and is expected to last (or has lasted) for at least 12 months, or is expected to result in death.

Payment levels are not based primarily on need, but on the rate and number

Table 14.1

SUMMARY OF INCOME ASSISTANCE TO MENTALLY
HANDICAPPED NEVADANS, FY 1974

Handicap and Expenditures	Program and Estimated Number Served			
	SSDI	SSI ^a	ADC	GA
Handicap				
Mental health problem	NA ^b	NA	>280	NA
Mental retardation	NA	NA	460	NA
Substance abuse	NA	NA	NA	NA
Total	450	350	>740	NA
Estimated expenditures	\$1,100,000	\$550,000	\$400,000	NA

NOTE: See text of this chapter for sources.

^aThe SSI program started in 1974. This is approximately the size of the program in late 1974 on an annualized basis; it is expected to grow rapidly to about 900 clients and over \$1.5 million per year.

^bNA = not available; data are insufficient to make a meaningful estimate.

of quarter-years of previous contribution to the system, subject to maximums and minimums. Under the childhood disability provisions of this program, a person aged 18 or older who has been disabled prior to his 22d birthday, and who is the child or grandchild of a retired or disabled worker, could receive payments of up to \$166 a month beginning September 1972, while the disabled child or grandchild of a deceased worker could receive up to \$256.90 beginning September 1972 if he earns \$125 or less per month. Because most mentally handicapped youth under age 22 have neither accumulated the required previous earnings record, nor have a retired, disabled, or deceased parent, only a small fraction actually receive benefits from this program.

Depending upon the amount of the monthly cash disability benefit under SSDI, a person may also be eligible for SSI.

Although the Nevada Bureau of Disability Adjudication determines eligibility for both SSDI and SSI because of mental disabilities, no current data are available in the bureau on how many mentally incapacitated Nevadans are supported in this manner, the nature of their disability, and how much they receive. State personnel rely on the Federal Government to provide statistics, and only in March 1975 did the Social Security Administration issue 1970 data.¹ Information that was made available to us is presented below.

The most recent data available on the types of disabilities of SSDI recipients in Nevada are from 1970, when a total of 494 per 100,000 Social Security insured workers were receiving SSDI and 44 per 100,000 (about 9 percent of the total) were receiving SSDI because of mental disabilities. Also in 1970, a total of 21 SSDI

¹ Interview with J. Penman, Nevada Bureau of Disability Adjudication, Carson City, Nevada, May 19, 1975.

recipients with mental disabilities (usually mental retardation) were eligible under the childhood disability provisions of the program.² A total of 4677 disabled Nevadans were eligible to receive various benefits under the SSDI program in 1974.³ If we use the 1970 figure of 9 percent for disabled insured workers who had a mental disability, and add about 25 or 30 mentally disabled people eligible under the childhood disability provisions, we arrive at an estimate of about 450 mentally disabled Nevadans on SSDI in 1974. Using an average monthly payment of \$207, the estimated expenditures for mentally disabled Nevadans receiving SSDI in FY 1974 was about \$1.1 million.⁴

SUPPLEMENTAL SECURITY INCOME

In 1972, Public Law 92-603 repealed such categorical assistance programs as Aid to the Permanently and Totally Disabled (APTD), Old Age Assistance (OAA), and Aid to the Blind (AB),⁵ and established a Supplemental Security Income (SSI) program for disabled, aged, and blind people. This program, which became effective January 1, 1974, is federally funded and operated, and provides uniform minimum payment levels and uniform eligibility requirements for recipients in all 50 states and the District of Columbia. To qualify, a disabled applicant must meet the income and resources test and be unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that either can be expected to result in death, or has lasted (or can be expected to last) for a continuous period of not less than 12 months.

Prior to the implementation of SSI, Nevada was the only state in the union without an APTD program. Although medical care through the Medicaid program was available to financially needy disabled people, direct cash transfers were not provided through an APTD program. The new SSI program establishes uniform minimum cash grants, completely funded with federal dollars, for the disabled group. In addition, the flat grants given by SSI replace the old OAA and AB grant programs, which involved a system of budgeting based on the needs of individual recipients.

States may supplement the federally paid minimum SSI grant. Federal payment levels for an eligible individual who does not have an eligible spouse were up to \$146 per month in FY 1975 for persons in independent living, reduced by the amount of the individual's nonexcludable income. Payments for an eligible individual who has an eligible spouse were \$219 a month, reduced by the amount of the individual's nonexcludable income (combined with that of his or her spouse). In July 1975, these federal payment levels rose to \$157.50 and \$236.60 for individuals and couples, respectively.⁶

Because these payment levels are lower than those typically provided under the old OAA and AB programs, Nevada provides "state supplementation" of the federal

² Ibid.

³ Nevada Rehabilitation Division, *Biennial Report*, Carson City, Nevada, 1975.

⁴ "Social Security Upped 8 Percent," *Las Vegas Review Journal*, May 16, 1975.

⁵ Social Security Act, Titles I, X, XIV.

⁶ E. Cocka, Social Security Administration District Manager, Las Vegas, as reported in *Las Vegas Review Journal*, July 10, 1975.

SSI check, but for the blind and aged only.⁷ With this addition, the grant level in Nevada for an aged person with no other income in FY 1975 was \$205 per month; for a blind person, \$235. In July 1975, those payment levels to aged and blind people rose to \$212.70 and \$265 per month, respectively.⁸ Because Nevada had no prior APTD grant program, the federal "hold harmless" provision does not apply to the disabled. Therefore, in FY 1976, the maximum a mentally disabled person can receive is the basic federal sum of \$157.50 a month, while a blind person can receive \$265 a month.

As with most states, the Social Security Administration has an agreement with the Nevada Rehabilitation Division to evaluate disability claims. Although disability decisions are made locally within Nevada, the headquarters of the Bureau of Disability Insurance of the federal Social Security Administration checks state data to assure national consistency. The federally supplied definitions of mental disabilities are given below.

12.01 CATEGORY OF IMPAIRMENTS, MENTAL

12.02 Chronic brain syndromes. Documented by mental status examination (supported, if necessary, by the results of appropriate, standardized psychological tests) establishing deterioration in intellectual functioning and manifested by marked restriction of daily activities and constriction of interests and deterioration in personal habits and seriously impaired ability to relate to other people and persistence of ONE of the following:

- A. Marked memory defect for recent events; or
- B. Impoverished, slowed, perseverative thinking, with confusion or disorientation; or
- C. Labile, shallow, or coarse affect.

12.03 Functional psychotic disorders (mood disorders, schizophrenic reactions, paranoid reactions). Manifested by marked restrictions of daily activities and constriction of interests and seriously impaired ability to relate to other people, and persistence of ONE of the following:

- A. Depression (or elation); or
- B. Agitation; or
- C. Psychomotor disturbances; or
- D. Hallucinations or delusions; or
- E. Autistic or other regressive behavior; or
- F. Inappropriateness of affect; or
- G. Illogical association of ideas.

12.04 Functional nonpsychotic disorders (psychophysiologic, psychoneurotic and personality disorders). Manifested by marked restriction of daily activities and constriction of interests and deterioration in personal habits and seriously impaired ability to relate to other people and persistence of ONE of the following:

- A. Demonstrable structural changes mediated through psychophysiologic channels (e.g., duodenal ulcer); or

⁷ PL 92-603 includes a "hold harmless" clause. In cases where states had been paying over the federal grant level, data from calendar year 1972 are used to establish an "adjusted payment level." That is, for contributing a fixed sum, the state is "held harmless" for future costs associated with the payment of grants up to the adjusted payment level.

⁸ Interview with R. Sineroff, Welfare Division, Nevada Department of Human Resources, July 21, 1975.

- B. Recurrent and persistent periods of anxiety, with tension, apprehension, and interference with concentration and memory; or
- C. Persistent depressive affect with insomnia, loss of weight, and suicidal ideation; or
- D. Phobic or obsessive ruminations with inappropriate, bizarre or disruptive behavior; or
- E. Compulsive, ritualistic behavior; or
- F. Persistent functional disturbance of vision, speech, hearing or use of a limb with demonstrable structural or trophic changes; or
- G. Life-long, habitual, and inappropriate patterns of behavior manifested by one of the following:
 - 1. Seclusiveness and autistic thinking; or
 - 2. Antisocial or amoral behavior (including pathologic sexuality) manifested by: (a) inability to learn from experience and inability to conform with accepted social standards, leading to repeated conflicts with society or authority and (b) by psychopathology documented by mental status examination and the results of appropriate, standardized psychological tests; or
 - 3. Addictive dependence on alcohol or drugs, with evidence of irreversible organ damage; or
 - 4. Pathologically inappropriate suspiciousness or hostility manifested by psychopathology documented by mental status examination and the results of appropriate, standardized psychological tests.

12.05 Mental deficiency. As manifested by:

- A. Severe mental and social incapacity as evidenced by marked dependence upon others for personal needs (e.g., bathing, washing, dressing, etc.) and inability to understand the spoken word and inability to avoid physical danger (fire, cars, etc.) and inability to follow simple directions and inability to read, write, and perform simple calculations; or
- B. IQ of 49 or less (see § 12.00C1); or
- C. IQ of 50 to 69, inclusive (see § 12.00C1) and:
 - 1. Inability to perform routine, repetitive tasks; or
 - 2. A physical or other mental impairment resulting in restriction of function.*

Every disability determination includes an evaluation of vocational rehabilitation potential, and persons who can reasonably be expected to benefit from vocational rehabilitation are referred for services (see Chap. 11). Titles XVI and II of the federal Social Security Act provide for reimbursements to VR agencies for rehabilitation services rendered for SSI recipients and selected SSDI beneficiaries.

An application for disability benefits must be accompanied by a medical report signed by a licensed physician. Mental retardation must be determined by a qualified psychologist or psychiatrist unless, as in many rural communities, they are not readily available. In these instances, a vocational rehabilitation counselor or trained school personnel may administer an IQ test "particularly when other findings are also consistent with low intellectual capacity."¹⁰

Alcoholism and drug abuse in themselves do not qualify a person as disabled (and hence eligible for SSI) even though the substance abuser is unable to hold a job. An alcoholic is certified as disabled only when the alcohol has caused a physical

* From *Disability Evaluation Under Social Security: A Handbook for Physicians*, Social Security Administration, SSI-89, July 1970, pp. 34-40.

¹⁰ Ibid.

disablement (e.g., liver or kidney disease). In these instances, the substance abuser may not directly receive SSI funds, but a representative or payee must be designated.

The SSI program began operation only in early 1974 and hence the number of disabled people¹¹ receiving benefits is growing rapidly and has not yet reached a steady state. A total of 609 disabled persons were allowed into the program in the July-December 1974 period¹² and 1047 had been determined eligible in total.¹³ We were unable to obtain data on the number of persons receiving both SSDI and SSI, or on the fraction of SSI recipients who are mentally disabled. Nationally, however, in the SSI predecessor program for disabled people (APTD), 35.1 percent of the recipient population had mental disorders.¹⁴ In the absence of better data, we estimate that about 35 percent of the 1047 Nevadans on SSI in 1974, or about 350, were mentally disabled.

To estimate the number of people that will be on the SSI caseload when the current rapid initial growth slows and the caseload approaches a steady-state fraction of the Nevada population, we looked to national experience with the predecessor APTD program, which all states except Nevada had up to 1974. The 1970 Census of Population showed a total of 1.55 million people in the United States aged 16 to 64 years old who had a work disability of 6 months or more duration and were not able to work. The comparable figure for Nevada was 3638 in 1970, or, allowing for population growth, about 4230 in 1974.¹⁵ Nationally, in December 1970 the APTD caseload was 935,000 or 60 percent of the 1.55 million people who were disabled and unable to work. Applying that percentage to the 4230 people in Nevada disabled and unable to work, aged 16 to 64 years old in 1974, yields an estimate of about 2500 Nevadans who might have been on SSI in 1974 if Nevada had had the predecessor APTD program. Consequently, as disabled people are admitted to the program, we feel that the figure of 1047 Nevadans actually on SSI may grow rapidly to approximately 2500 before leveling off at approximately the rate of growth of the general population in Nevada. If the number of mentally disabled people on SSI grows at the same rate as the total SSI caseload, it would advance rapidly from the present 350 or so up to approximately 900.

The FY 1975 average payment level per person is unknown but is less than the maximum of \$146 per month, because of adjustments for an individual's nonexcludable income and other factors. If we arbitrarily use an average of \$130 per month to get an order of magnitude estimate for total SSI payments to mentally handicapped Nevadans, we estimate the total to be approximately \$550,000 in 1975, and that it will grow rapidly toward approximately \$1.5 million before leveling off in 1977.

¹¹ Recall that the Social Security Administration uses the term "disability" to mean inability to work because of a physical or mental impairment that has lasted (or is expected to last) for one year or more, or is expected to result in death.

¹² Interview with J. Freeman.

¹³ Nevada Rehabilitation Division, *Biennial Report*.

¹⁴ U.S. Department of Health, Education, and Welfare, *Findings of the 1970 APTD Study, Part I. Demographic and Program Characteristics, Social and Rehabilitation Services*, DHEW Publication No. (SRS) 73-00863, Washington, D.C., September 1972.

¹⁵ U.S. Bureau of the Census, "Characteristics of the Population—Nevada," *1970 Census of Population*, Vol. 1, Part 30, January 1973.

AID TO DEPENDENT CHILDREN

The Aid to Dependent Children (ADC) program provides financial assistance to needy families with children, and to handicapped children or adults only if they belong to an ADC recipient family. During FY 1974, about 14,000 persons in Nevada qualified for ADC and received an average payment of \$45 a month. Of this, the Federal Government paid \$22. Beginning in FY 1976, the average ADC payment level will be approximately \$54 per person, or about 70 percent of the need according to the State Welfare Division.¹⁶ Of this, the Federal Government will pay half. Although there are federal guidelines and federal financial participation,¹⁷ the program is state-administered, with the State Welfare Division deciding eligibility and grant determination. In Nevada, ADC covers needy dependent children (and their caretaker relatives) who are deprived of parental care or support because of death, absence, or physical or mental incapacitation of a parent.¹⁸

As described in Chap. 12, medical care is available to all ADC recipients through the Medicaid program. In addition, all children who qualify for the ADC program are eligible for and are supposed to receive early and periodic screening under Medicaid to detect physical and mental problems. (See Chap. 6 for a description of the screening program.) ADC payments are lower than SSI payments, but a disabled child who is identified by the early screening program under Medicaid or by some other means can be transferred to the higher-paying SSI program. It should be noted, however, that even the SSI payments to disabled people fall below the federal poverty line.

Federal guidelines allow two optional programs that Nevada Welfare has not taken advantage of: an AFDC-U program (for "intact" families where the father is in the home but unemployed), and "Emergency Assistance." Currently, persons who would qualify for these programs (if adopted by the state) must rely on county welfare support for income assistance and frequently for medical care.

COUNTY INCOME ASSISTANCE PROGRAMS

Indigent persons who do not qualify for SSDI, SSI, or ADC must rely on their counties for help. Among this group will be the alcoholic or drug abuser who is not yet physically disabled, the person with a mental health problem or mental retardation who has not yet been accepted by SSI (the wait in 1974 was several months), the person with a mental health problem that renders him or her temporarily unable to find or hold a job but is not expected to last 12 months, and payments to an intact family with the wage-earner(s) temporarily unemployed.

In examining what general assistance funds are available for these persons, we gathered data from the largest counties, Clark and Washoe. Although programs differ between the counties, support is minimal at best. Both counties provide direct support to indigents. However, administrators of both agencies agree that the level of support is not enough to live on. State Welfare takes the position that general

¹⁶ Interview with R. Sineroff.

¹⁷ United State Codes, Title 42, Sec. 602-607.

¹⁸ For a detailed description, see Nevada State Welfare Division, *Eligibility and Payments*, September 7, 1973, Sec. 202.7.

assistance is "traditionally and legally the sole responsibility of county government," and will not reimburse the counties even for income assistance granted while an SSI application is pending.¹⁸

Clark County Welfare. With a division budget of approximately \$3.8 million for FY 1974, \$1.4 million went for Medicaid, \$1.0 million for medical aid for indigents not eligible for Medicaid, and \$1.4 million for the cash assistance program. For "eligible resident applicants," the amounts available are as displayed in Table 14.2.

Table 14.2
INCOME MAINTENANCE AVAILABLE FROM
CLARK COUNTY WELFARE
(In \$)

Size of Household	Standard of Monthly Need	Proposed Maximum Amount to Be Given
1	170	77
2	222	100
3	290	131
4	330	149
5	385	173
6	435	196
7	470	212
8	510	230
9	555	250
10	595	268

SOURCE: *Clark County Social Service Program*, brochure received from Barbara Brady, Clark County Social Services Division, Las Vegas, Nevada, October 25, 1974.

Clark County financially supports severely mentally retarded indigents from age 0 to 2, i.e., until they are of an age when they are eligible for admission to the Nevada Mental Health Institute. In their view, all other mentally retarded people are the responsibility of the state or Federal Government, or both.

The Nevada Mental Health Institute is legally required to give ten days notice to the county of origin before returning an indigent. Those who do not qualify for SSI either go into nursing homes, at the expense of the county, or they are left in the community because of lack of alternate living accommodations. (The Clark County Director of Social Services stated that most group homes are for the elderly, and that psychiatric patients are refused admittance in most cases.)

Washoe County Welfare. In several significant ways, the Washoe welfare program differs from that of Clark County. No welfare is provided to indigent single persons or to a married couple without children unless they are certified as unemployable. These persons typically are alcoholic and other substance abusers who are not certified disabled under definitions used by the Bureau of Disability Adjudication. No welfare is available to mentally retarded people, who are viewed as being

¹⁸ From a letter from George E. Miller, State Welfare Administrator, to Barbara Brady, Director of Clark County Social Services, October 17, 1974.

the responsibility of the Nevada State Welfare Division. For those who qualify, county welfare provides much less than half of their standard of need, as shown in Table 14.3.

Table 14.3

INCOME MAINTENANCE AVAILABLE FROM WASHOE COUNTY WELFARE
(In \$)

Size of Household (One Adult Plus Children)	Standard of Monthly Need	Maximum Amount to be Given
1	173	64
2	229	89
3	279	109
4	329	128
5	381	149
6	424	166
7	466	182

SOURCE: Washoe County Welfare Department, *Guidelines and Standards*, 1974.

RECOMMENDATIONS

Without accurately knowing both the numbers of mentally handicapped persons receiving financial assistance and the nature of their disabilities, there is no adequate way to plan and evaluate the system. The collection and assessment of these types of data would provide the necessary feedback to evaluate the present system, help assess its effectiveness, and meet those service needs exposed. Without adequate information in a usable format, it is not possible to ensure the provision of other needed nonfinancial assistance services. The income assistance rolls are an excellent potential source of referrals for other programs; it is a source that has not been fully tapped, with the possible exception of referrals of SSI applicants for vocational rehabilitation. We recommend that the Nevada Department of Human Resources identify each mentally handicapped person receiving financial assistance, refer him or her to other appropriate service programs (or to the Direction Centers we recommended in Chap. 4), and maintain much more complete program planning data.

To facilitate the identification of mentally handicapped Nevadans, we recommend that the ADC program adopt procedures to ensure that all recipients are screened for mentally handicapping conditions under the Medicaid program (see Chap. 6).

Regarding the level of financial assistance per person, we recommend that any mentally handicapped ADC recipients who are also eligible for SSI be transferred to the higher-paying (and primarily federally financed) SSI program. This would not only provide a more nearly adequate income for the mentally handicapped people involved, but would do so at less cost to the state (although at more cost to the Federal Government). The improved screening recommended above would facilitate

this. Even the current SSI maximum payment schedule, however, runs *below* that of the federal poverty level. The Office of Economic Opportunity's poverty level (as of May 22, 1974) is \$2330 a year for one person, and the Bureau of the Census uses a poverty level of \$2396 per year (as of 1973) for a nonfarm male individual under age 65 living alone.²² However, SSI payments for a disabled person living independently were a maximum of \$1890 in July 1975; an individual's other sources of direct or indirect income may result in an actual payment below the maximum allowable. While nonfinancial assistance is also provided to mentally handicapped people on financial assistance programs (see Chaps. 4 to 13 of the main text for discussions of those other services), most basic needs such as housing, utilities, and clothing, are met through direct cash transfers. Given that the maximum SSI payment is lower than the federal poverty level, *we recommend that the State of Nevada supplement the federal SSI payments to mentally disabled people to provide a more nearly adequate level of income assistance.* In order for income assistance to continue to fulfill the function it was designed for, the state supplementary figure should periodically make allowances for inflation. We note that the state currently provides a supplement to the federal SSI payment for other categories of SSI recipients for whom the cost of meeting basic living needs is not clearly higher than it is for mentally handicapped Nevadans.

²² See U.S. Bureau of the Census, "Characteristics of the Low Income Population: 1973," *Current Population Report*, Series P-60, No. 96, January 1975, p. 161; and "Characteristics of the Population—Nevada," *1970 Census of Population*, Vol. 1, Part 30, January 1973, pp. 30-102.

Appendix A

DETAILED VOCATIONAL REHABILITATION PROGRAM AND CLIENT CHARACTERISTICS

This appendix contains a detailed presentation of data on VR program and client characteristics for FY 1974 case closures, by type of mental handicap and outcome of the services. Topics discussed include sources of referrals; destinations of persons referred elsewhere by VR; outcomes of referrals to VR and the reasons for non-acceptance of people as clients and for nonrehabilitation of clients; age, sex, race, Spanish surnames, education, previous VR service, and secondary disabilities of clients; services provided; time spent in the VR program; client earnings and sources of support at time of referral and time of case closure; and occupations of rehabilitants.

SOURCES OF REFERRALS

In FY 1974 VR case closures, as shown in Tables A.1 and A.2, the four largest sources of referrals of mentally disabled persons were mental hospitals, welfare agencies, correctional and court agencies, and self-referred persons. Surprisingly, educational institutions referred only 48 people in the entire year, or only 3 percent of all referrals.¹ Four other sources that appear to be sending very few mentally disabled people in relation to the number they are in contact with are state Employment Security personnel (49 referrals), private physicians (26), public health personnel (67), and Community Mental Health Centers (only 81 referrals).

REFERRAL DESTINATIONS

Of all people referred or applying to the VR Bureau but not accepted for service, less than 3 percent of those who reportedly were mentally disabled were referred elsewhere by VR personnel for service. If this low figure indicates that VR personnel are not offering needed referral guidance to people they do not accept for service, then Nevada has a great opportunity to improve the quality of "direction" services at very low cost. As shown in Table A.3, the few people referred elsewhere are most often referred to a welfare agency.

OUTCOMES OF REFERRALS TO THE BUREAU OF VOCATIONAL REHABILITATION

Of the 1974 case closures, mentally disabled persons not accepted for service

¹ These youth are mostly from Clark County, where VR counselors do some work with the schools. In general, however, VR personnel in Nevada do not go to the schools looking for potential clients. (Interview with Lloyd Mack, Jr., Deputy Administrator, Nevada Rehabilitation Division, Carson City, Nevada, May 9, 1974.)

Table A.1

**SOURCES OF REFERRAL FOR VOCATIONAL REHABILITATION OF MENTALLY
DISABLED PERSONS, FY 1974 CLOSURES**

Source	Persons Not Accepted		Number Not Rehabili- tated	Number Rehabili- tated	Total	
	No.	%			No.	%
Educational institution	23	48	9	16	48	3
Mental hospital (public and private)	173	57	94	34	301	20
Community Mental Health Center	33	41	15	33	81	5
Public health department, organ- ization, or agency	23	34	17	27	67	4
Other public or private health organization or agency	36	57	10	17	63	4
Welfare agency	114	53	47	55	216	14
Social Security	72	84	7	7	86	6
State Employment Service	31	63	5	13	49	3
Correctional institution, court, or officer	111	59	50	26	187	12
Other public organization or agency	26	55	7	14	47	3
Other private organization or agency	26	58	9	10	45	3
Self-referred	107	59	46	27	180	13
Individual physician	10	38	7	9	26	2
Other individual	57	46	21	46	124	8
Total	842	55	344	334	1520	100

SOURCE: Rand analysis of FY 1974 "Case Service Reports."

NOTE: Percentages in "Total" column do not add to 100, because of rounding.

accounted for 55 percent of the total number of reportedly mentally disabled persons referred. This figure varied markedly, however, across the more prevalent reported types of mental disability: from 64 percent of those reported to be psychotic, to 63 percent of those having some "other mental disorder" of character, personality, or behavior, to 40 percent of those reported to be mentally retarded, to 21 percent of those reported to be psychoneurotic. Of those accepted for service, 49 percent were successfully rehabilitated. The success rate varied, for the more prevalent types of mental disorders, from a low of 26 percent for psychotics to a high of 72 percent for drug-abusers (see Table 11.3). The reasons for non-acceptance and nonrehabilitation of referrals and clients are discussed below.

Of the 55 percent of FY 1974 case closures involving people who reportedly had mental disabilities but were not accepted for service, only small fractions were not accepted because they had too severe a disability or an unfavorable medical prognosis (5 percent), no disabling condition (5 percent), or no vocational handicap (3 percent). Over 80 percent of those applicants not accepted for service were so because they could not be located or contacted, or had moved (43 percent), had refused service (17 percent), or failed to cooperate (5 percent); unreported or "other" reasons accounted for 17 percent; (see Table A.4.) The obvious and significant message from these data is that a large percentage of unaccepted applicants actually may be qualified to receive service, but are not served for one reason or another. According

Table A.2
SOURCES OF REFERRAL OF SUCCESSFUL VOCATIONAL REHABILITANTS, BY TYPE OF
MENTAL DISABILITY, FY 1974 CLOSURES

Source	Alcoholism	Drug Addiction	MR, Mild	MR, Moderate	MR, Severe	Psychotic	Psycho- neurotic	Other Mental Disorder	Epilepsy	Cerebral Palsy	Stroke	Total
Educational institution	0	0	7	4	1	0	1	2	1	0	0	15
Mental hospital, public or private	16	1	0	0	0	11	4	2	0	0	0	34
Community Mental Health Center	2	1	0	0	0	4	8	18	0	0	0	33
Public health department organ- ization, or agency	2	22	1	1	0	0	1	2	0	0	0	27
Other public or private health organization or agency	3	9	0	0	0	0	0	2	0	1	0	17
Welfare agency	0	0	5	2	0	1	7	35	4	0	1	55
Social Security	0	0	1	0	0	0	2	2	1	1	0	7
State Employment Service	1	0	3	0	0	0	2	5	2	0	0	13
Correctional institution, court, or officer	0	3	0	0	0	0	0	22	1	0	0	26
Other public organization or agency	4	1	1	0	0	1	2	4	1	0	0	14
Other private organization or agency	1	2	4	3	0	0	0	0	0	0	0	10
Self-referred	2	2	2	2	0	3	5	8	2	0	0	27
Individual physician	0	1	1	0	0	0	4	3	0	0	0	9
Other individual	5	4	12	2	0	0	1	19	1	0	2	46
Total	36	46	37	14	1	20	37	124	13	3	3	334

SOURCE: Rand analysis of FY 1974 "Case Service Reports."

Table A.3

AGENCIES TO WHICH BUREAU OF VOCATIONAL REHABILITATION
REFERRED MENTALLY DISABLED PERSONS, FY 1974 CLOSURES
(In percent)

Referral to:	Persons Accepted as VR Clients	Persons Not Accepted as VR Clients
Educational institution	0.1	0.5
Health organization or agency	0.0	0.5
Welfare agency	0.0	1.1
State Employment Service	0.0	0.1
Other public organization or agency	0.0	0.1
Total reported as referred	0.1	2.3
Total reported as not referred	99.9	97.7

to Rehabilitation Division personnel,² "failure to cooperate" in practice usually means the referred or applying persons did not show up for appointments; "unable to locate or contact, or moved" sometimes means the person moved, but usually means that three unsuccessful attempts were made to contact the person by letter or telephone; and "other" reasons are diverse. The categories of reasons given on the reporting form are not nearly as informative as they might be. One may reasonably ask, for example, why 43 percent could not be located or contacted or had moved, and why 24 percent refused services or failed to cooperate.

The prime reason for nonrehabilitation of all prevalent types of mentally disabled persons that are accepted into the VR program is that they "drop out." In FY 1974, three-quarters of the nonrehabilitants were drop-outs: 52 percent could not be located or contacted or had moved, and 23 percent refused further services or did not cooperate and hence were classified as nonrehabilitants. Only 14 percent failed to be rehabilitated because their disability was too severe or they had an unfavorable medical prognosis or they were institutionalized, transferred to another service agency, or died. (See Table A.5.) "Dropping out" is also the predominant reason for the nonrehabilitation of mentally disabled persons who were in extended evaluation. The purpose of extended evaluation is supposed to be "determination of rehabilitation potential"; a person is placed into a 6- or 18-month extended evaluation after certification of: 1) the presence of a physical or mental disability, 2) the existence of a substantial handicap to employment, and 3) the inability to make a determination that rehabilitation services may render the person fit to engage in a gainful occupation.³ Yet the vast majority of nonrehabilitants whose cases were closed from extended evaluation status in FY 1974 were drop-outs; they did not leave because it had been determined that rehabilitation services probably would not fit them for gainful employment.

² Interview with Lloyd B. Mack, Jr., Deputy Administrator, and others, in the Rehabilitation Division, Nevada Department of Human Resources, Carson City, Nevada, May 9, 1974.

³ Rehabilitation Division, *Rehabilitation Services Manual for Case Finding, Intake, Case Reporting, Client Service Funding*, Sec. 2.2200, Department of Human Resources, Carson City, Nevada, November 1970.

Table A.4
REASONS MENTALLY DISABLED PERSONS WERE NOT ACCEPTED IN VR PROGRAM, FY
1974 CLOSURES

Reason Not Accepted	Percentage of Persons by Reported Disability Group										Stroke	Total
	Alcoholism	Drug Addiction	MR, Mild	MR, Moderate	MR, Severe	Psychotic	Psycho- neurotic	Other Mental Disorder	Epilepsy	Cerebral Palsy		
Unable to locate or contact, or moved	49	58	34	35	40	43	44	42	49	20	30	43
Handicap too severe, or unfavorable medical prognosis	10	0	12	29	20	7	0	1	15	40	20	5
Person refused services	17	12	15	6	20	11	9	20	27	20	30	17
Death	1	0	0	0	0	1	0	<1	0	0	0	<1
Client institutionalized	0	0	3	0	0	3	9	4	0	0	0	3
Transfer to another agency	0	2	0	0	0	0	0	0	0	0	0	<1
Failure to cooperate	2	16	9	0	0	3	23	7	6	0	0	7
No disabling condition	0	0	12	0	20	0	9	7	0	0	0	5
No vocational handicap	1	0	9	0	0	1	0	4	0	0	10	3
Other, or reason not given	20	12	15	29	0	31	8	14	3	20	10	17
Total	100	100	100	100	100	100	100	100	100	100	100	100

SOURCE: Rand analysis of FY 1974 "Case Service Reports."

NOTE: Columns may not add to 100 because of rounding.

Table A.5
REASONS MENTALLY DISABLED PERSONS WERE NOT REHABILITATED BY VR PROGRAM, FY 1974 CLOSURES

Persons Not Rehabilitated	Percentage of Persons by Disability Group										All Mental Disabilities Combined		
	Alcoholism	Drug Addiction	MIL, Mild	MIL, Moderate	MIL, Severe	Psychotic	Psychotic neurotic	Other Mental Disorder	Epilepsy	Stroke		Cerebral Palsy	Parkinson's Disease
Nonrehabilitation Closures of 198 Clients from Active Closures ^a													
Unable to locate or contact, or moved	67	55	50	67	0	46	55	81	50	0	100	—	53
Standing too severe, or unfavorable medical prognosis	22	15	0	0	0	14	13	1	0	0	0	—	7
Person refused services	6	5	50	0	0	0	10	12	17	0	0	—	11
Death	0	0	0	0	0	0	0	2	17	100	0	—	3
Client institutionalized	0	0	0	0	0	5	0	6	0	0	0	—	4
Transfer to another agency	0	0	0	0	0	0	0	0	0	0	0	—	1
Failure to cooperate	0	0	20	0	0	13	2	14	17	0	0	—	12
No disabling condition	0	0	0	0	0	0	0	0	0	0	0	—	0
No vocational handicap	0	0	0	0	0	0	0	0	0	0	0	—	0
Other, or reason not given	6	0	50	23	100	5	15	14	0	0	0	—	12
Nonrehabilitation Closures of 145 Clients from Extended Evaluation Status													
Unable to locate or contact, or moved	64	43	0	0	0	40	50	47	25	100	—	0	43
Standing too severe, or unfavorable medical prognosis	5	0	43	71	0	20	6	2	25	0	—	100	14
Person refused services	5	0	20	0	0	6	25	24	25	0	—	0	14
Death	0	0	0	0	0	0	0	0	0	0	—	0	1
Client institutionalized	0	0	14	0	0	0	0	7	0	0	—	0	4
Transfer to another agency	0	0	0	0	0	0	0	0	0	0	—	0	0
Failure to cooperate	5	14	14	14	0	2	12	12	25	0	—	0	10
No disabling condition	0	0	0	0	0	0	0	0	0	0	—	0	0
No vocational handicap	0	0	0	0	0	0	0	0	0	0	—	0	0
Other, or no reason given	22	43	0	14	100	20	5	7	0	0	—	0	14

SOURCE: Based analysis of FY 1974 "Case Service Reports."

NOTE: Column may not add to 100 because of rounding.

^aOf these closures, 94 percent were made after services were begun under a rehabilitation plan (i.e., closure from Status 20). Only 12 percent were closed before services were initiated (i.e., closure from Status 20). These do not include rehabilitants closed from extended evaluation status.

AGE

Nearly all mentally disabled VR clients were between the ages of 18 and 61 at the time of case closure; only two successful rehabilitants were under 18 and only 10 were 62 years or older. As shown in Table A.6, slightly less than two-thirds were between 18 and 36. The age distributions of those persons rejected, those not rehabilitated, and those rehabilitated are quite similar.

The types of disabilities of case closures under age 22 were heavily dominated by "other mental" and "mental retardation." "Mental retardation" applied to 41 percent of the successes, but to only 18 percent of the nonrehabilitants and 10 percent of the rejections. "Other mental disability" applied to 31 percent of the successes, 56 percent of the nonrehabilitants, and fully 75 percent of the rejections.

For people over age 35, the most common disability among both those served and those rejected was again "other mental." Alcoholism and psychosis were also prevalent reported disabilities among those older people rejected, while prevalent disabilities among those older persons served included alcoholism, psychosis, and psychoneurosis. Details for successful rehabilitants are shown in Table A.7.

Table A.6

MENTALLY DISABLED VR CLIENTS BY AGE GROUP, FY 1974 CLOSURES

Outcome	Number and Percent in Age Group					
	1-17	18-21	22-35	36-50	51-61	62+
Not accepted	33 (4%)	187 (22%)	361 (43%)	155 (18%)	81 (10%)	25 (3%)
Rehabilitated	2 (1%)	64 (19%)	154 (46%)	77 (23%)	27 (8%)	10 (3%)
Not rehabilitated	13 (4%)	81 (24%)	135 (39%)	77 (22%)	31 (9%)	7 (2%)

SOURCE: Rand analysis of FY 1974 "Case Service Reports."

Table A.7

PERCENTAGE OF REHABILITATED CLIENTS BY AGE AND
DISABILITY GROUP, FY 1974 CLOSURES

Disability Group	Age Group					
	0-17	18-21	22-35	36-50	51-61	62+
Alcoholism	0	0	3	23	40	20
Drug addiction	0	3	23	9	7	0
MR, mild	0	33	10	1	0	10
MR, moderate	0	8	5	3	0	0
MR, severe	0	2	0	0	0	0
Psychotic	0	3	5	9	11	0
Psychoneurotic	0	3	8	16	15	40
Other mental disorder	100	45	36	34	19	30
Epilepsy	0	2	7	3	0	0
Cerebral palsy	0	0	2	0	0	0
Stroke	0	2	0	0	7	0
Total	100	100	100	100	100	100

SOURCE: Rand analysis of FY 1974 "Case Service Reports."

NOTE: Percentages may not total to 100 because of rounding.

SEX

Of all reportedly mentally disabled persons referred to or applying for VR, 45 percent were female. As shown in Table A.8, however, women accounted for 55 percent of those accepted for service, and 57 percent of those rehabilitated in FY 1974.

Table A.8

SEX OF MENTALLY DISABLED PERSONS IN
VR CASELOAD, FY 1974 CLOSURES
(In percent)

Outcome	Female	Male
Not accepted	45	55
Rehabilitated	57	43
Not rehabilitated	52	48

SOURCE: Rand analysis of FY 1974 "Case Service Reports."

RACE AND SPANISH SURNAME

Of all mentally disabled persons whose VR service was completed in FY 1974, approximately 10 percent were black, 3 percent were Indian, and 3 percent were "other" (see Table A.9). The prevalence of Spanish surnames among those completing service was approximately 3 percent. (See Table A.10.) The tables also include data on race and Spanish surname prevalence among persons not accepted for service, but the data are incomplete and therefore not wholly reliable; one-third of

Table A.9

RACE OF MENTALLY DISABLED PERSONS IN
VR CASELOAD, FY 1974 CLOSURES
(In percent)

Race	Outcome		
	Not Accepted	Rehabilitated	Not Rehabilitated
White	54	53	53
Black	6	11	10
Indian	4	2	4
Other	2	3	3
Race data not recorded	34	0	0

SOURCE: Rand analysis of FY 1974 "Case Service Reports."

NOTE: "Rehabilitated" column does not total to 100 because of rounding.

Table A.10

PREVALENCE OF SPANISH SURNAMES FOR MENTALLY DISABLED
PERSONS IN VR CASELOAD, FY 1974 CLOSURES
(In percent)

Surname	Outcome		
	Not Accepted	Rehabilitated	Not Rehabilitated
Spanish	3	4	3
Non-Spanish	63	96	97
Data not recorded	34	0	0

SOURCE: Rand analysis of FY 1974 "Case Service Reports."

the records on those not accepted did not contain race and Spanish surname data. For comparison, the 1970 Census of Population⁴ indicated the following for Nevada: 6.2 percent black; 1.8 percent Indian; 1.1 percent "other"; and 4.6 percent Spanish origin.

EDUCATION

Tables A.11 and A.12 give the distribution of educational achievement by outcome of the VR process and type of mental disability. Rehabilitated clients had a slightly higher median level of education than nonrehabilitants and persons not accepted for service, although about half of each group had completed high school or more. About one in six rehabilitants, and one in four of those not accepted and those not rehabilitated, had a ninth-grade education or less. Alcoholics and psychoneurotics tended to have more post-high-school education than other mental disability groups, while retarded persons and alcoholics were more likely than other mental disability groups to have a ninth-grade education or less.

PREVIOUS VR SERVICE

About one out of every six mentally disabled clients whose cases were closed in FY 1974 were repeat clients. They had received VR services before, and had had another prior case closure; the majority had not been successfully rehabilitated then. (See Table A.13.) Just over one-third of the previous case closures had occurred within the previous six months, and about one-quarter had occurred more than 18 months previously.

SECONDARY DISABILITIES

In addition to the primary mental disabilities of the VR clients we analyzed,

⁴ "Characteristics of the Population," 1970 Census of Population, Vol. 1, Part 30: Nevada, U.S. Bureau of the Census, January 1973.

Table A.11

**MENTALLY DISABLED VR CLIENTS BY HIGHEST EDUCATIONAL
LEVEL ATTAINED, FY 1974 CLOSURES**
(In percent)

Outcome	Grade				Some Post- High-School Education	College Graduate	MR Class
	0-6	7-9	10-11	12			
Not accepted	4	21	30	35	8	3	0
Rehabilitated	3	10	31	42	6	4	3
Not rehabilitated	3	19	32	36	8	2	<1

SOURCE: Rand analysis of FY 1974 "Case Service Reports."

NOTE: Rows may not total to 100 because of rounding.

Table A.12

**REHABILITATED CLIENTS BY HIGHEST EDUCATIONAL LEVEL ATTAINED
AND MENTAL DISABILITY GROUP, FY 1974 CLOSURES**
(In percent)

Disability Group	Grade				Some Post- High-School Education	College Graduate	MR Class
	0-6	7-9	10-11	12			
Alcoholism	3	17	25	36	14	6	0
Drug addiction	0	4	41	48	7	0	0
MR, mild	8	8	41	30	0	3	11
MR, moderate	14	7	7	50	0	0	21
MR, severe	0	0	100	0	0	0	0
Psychotic	0	5	25	60	8	5	0
Psychoneurotic	5	3	22	49	16	5	0
Other mental disorder	2	16	30	42	4	6	1
Epilepsy	8	8	46	31	8	0	0
Cerebral palsy	0	0	33	33	0	0	33
Stroke	0	0	33	33	0	33	0
All mental disabilities combined	3	10	31	42	6	4	3

SOURCE: Rand analysis of FY 1974 "Case Service Reports."

NOTE: Rows may not total to 100 because of rounding.

about one-third were reported to have secondary impairments, residual defects, or other disabling conditions that contribute to but are not the major basis of their employment handicaps. Among mentally disabled clients, nonrehabilitants were slightly more likely to have such secondary disabilities than were rehabilitants, as is expected (35 versus 29 percent, respectively). Just over half the secondary disabilities reported for mentally disabled clients were physical disabilities. The most frequent types of secondary mental disabilities were alcoholism and "other mental disorders" of character, personality, or behavior. (See Table A.14). About 15 percent of the VR clients whose primary disability was physical were reported to have secondary mental disabilities, most frequently psychoneurosis or some "other men-

Table A.13

PERCENTAGE OF VR CLIENTS WITH PREVIOUS CASE CLOSURES,
FY 1974 CLOSURES

Mental Disability Group	Previously "Rehabilitated"	Previously "Not Rehabilitated"	Not Previously Served
Rehabilitated in FY 1974			
Alcoholism	8	6	87
Drug addiction	11	5	85
MR, mild	0	5	95
MR, moderate	7	36	57
MR, severe	0	0	100
Psychotic	5	15	80
Psychoneurotic	3	8	89
Other mental disorder	2	9	89
Epilepsy	8	15	77
Cerebral palsy	0	33	67
Stroke	0	33	67
All mental disabilities combined	5	10	86
Not Rehabilitated in FY 1974, Closure from Extended Evaluation			
Alcoholism	0	14	86
Drug addiction	0	14	86
MR, mild	0	43	57
MR, moderate	0	15	86
MR, severe	0	0	100
Psychotic	0	20	80
Psychoneurotic	0	13	88
Other mental disorder	4	11	84
Epilepsy	0	25	75
Stroke	0	0	100
Parkinson's disease	0	0	100
All mental disabilities combined	1	16	83
Not Rehabilitated in FY 1974, Closure from Active Caseload			
Alcoholism	0	0	100
Drug addiction	0	18	82
MR, mild	10	10	80
MR, moderate	0	0	100
MR, severe	0	100	0
Psychotic	5	36	59
Psychoneurotic	13	10	77
Other mental disorder	3	5	92
Epilepsy	0	17	83
Cerebral palsy	0	0	100
Stroke	0	0	100
All mental disabilities combined	5	11	85

SOURCE: Rand analysis of FY 1974 "Case Service Reports."

NOTE: Rows may not total to 100 because of rounding.

Table A.14
NUMBER OF CLIENTS WITH SECONDARY DISABILITIES, FY 1974 CLOSURES

Secondary Disability	Major Disability												Total, All Physical and Mental Disabilities	
	Alcoholism	Drug Addiction	MR, Mild	MR, Moderate	MR, Severe	Psychotic	Psychotic neurotic	Other Mental Disorder	Epilepsy	Cerebral Palsy	Stroke	Parkinson's Disease		
Not Rehabilitated														
Alcoholism	0	0	0	0	0	2	1	7	0	0	0	0	10	19
Drug addiction	0	0	0	0	0	3	2	4	0	0	0	0	9	9
MR mild	0	0	0	0	0	2	1	1	0	1	0	0	5	7
MR moderate	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MR severe	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Psychotic	1	0	0	0	0	0	0	2	0	0	0	0	4	4
Psychoneurotic	1	0	0	1	0	0	0	2	1	0	0	0	5	13
Other mental disorders	4	2	9	1	0	0	3	0	2	0	1	0	22	32
Epilepsy	0	0	0	1	0	1	0	0	0	0	0	0	2	3
Cerebral palsy	0	0	1	1	0	0	0	0	0	0	0	0	1	2
Stroke	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Physical disability	7	5	4	1	1	3	12	23	2	0	1	1	62	131
No secondary disability	27	11	2	6	1	46	37	96	5	0	0	0	223	346
Percent with some secondary disability	33	30	53	40	50	19	43	20	50	100	50	100	26	39
Rehabilitated														
Alcoholism	0	0	0	0	0	1	2	1	0	0	0	0	4	10
Drug addiction	1	0	0	0	0	0	0	2	0	0	0	0	3	7
MR mild	0	0	0	0	0	0	0	1	1	0	0	0	2	5
MR moderate	0	0	0	0	0	0	0	0	0	0	0	0	0	1
MR severe	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Psychotic	1	0	0	0	0	0	0	2	1	0	0	0	4	6
Psychoneurotic	1	0	1	0	0	0	0	1	0	0	0	0	3	12
Other mental disorders	6	5	2	2	0	1	0	0	4	0	0	0	20	55
Epilepsy	0	0	1	0	1	0	1	1	0	0	0	0	4	5
Cerebral palsy	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Stroke	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Physical disability	3	2	1	2	0	2	8	20	1	2	1	0	34	203
No secondary disability	19	29	33	10	0	16	35	56	6	1	2	0	236	519
Percent with some secondary disability	47	16	14	29	100	20	23	21	53	67	33	NA ^a	29	37

SOURCE: Based on analysis of FY 1974 "Case Service Reports."

^aNA = not available.

SOURCE: Rand analysis of FY 1974 "Case Service Reports."

^aNA = not applicable.

tal disorder" of character, personality, or behavior. However, statistics presented throughout this appendix deal only with persons whose *primary* disability is mental.

SERVICES PROVIDED

In addition to services such as vocational planning, counseling, guidance, and job placement, which VR clients receive directly from rehabilitation counselors employed by the Nevada Bureau of Vocational Rehabilitation, the Bureau usually provides or purchases one or more other services for clients. They include:

- Diagnosis and evaluation, including transportation and hospital and professional fees for medical, psychological, social, and vocational diagnostic and evaluation services to determine eligibility or scope of other services needed.
- Restoration (physical or mental): medical or medically related services, psychiatric and therapeutic treatment services, to correct or substantially modify a physical or mental condition.
- Training, including training materials, tools, and equipment; training in a college, university, high school, elementary school, business school, or vocational school; or on-the-job training and training in personal and vocational adjustment.
- Income maintenance: basic living expenses, if necessary.
- Service to other family members: services that contribute substantially to rehabilitation of the handicapped person.
- Other services, including reader or interpreter services, occupational tools and equipment, initial stocks, licenses, or transportation.^a

As seen in Table A.15, nearly all mentally disabled clients receive diagnostic and evaluation services. Mental or physical restorative services are provided to about one in three rehabilitants and one in five nonrehabilitants; about the same fractions receive income maintenance payments during rehabilitation. The fact that nonrehabilitants receive fewer of most types of services is at least partially explainable by their "dropping out" or leaving the program before they are able to receive some of the services planned for them. Training of one or more types is often provided to rehabilitants: 75 percent were given personal or vocational adjustment training; 13 percent were trained on the job; 15 percent attended a vocational school; 13 percent attended a business school, 7 percent an elementary or high school training program; and 6 percent attended a college or university for training. And 39 percent of the mentally disabled rehabilitants received "other services." Other members of the mentally disabled rehabilitant's family are seldom provided services (only 4 percent of the families).

From the data above on the number of people receiving each type of training, it was not possible to ascertain how many people received little or no training, since

^a Rehabilitation Services Manual, Sec. 2.3600.

Table A.15
 PERCENTAGES OF VR MENTALLY DISABLED CLIENTS RECEIVING VARIOUS TYPES OF
 SERVICES, FY 1974 CLOSURES

Service	Disability Group										Parkinson's Disease	Stroke
	All Mental Disabilities Combined	Alcoholism	Drug Addiction	MR, Mild	MR, Moderate	MR, Severe	Psychotic	Psychoneurotic	Other Mental Disorder	Epilepsy	Cerebral Palsy	
Diagnosis and evaluation												
Not rehabilitated	97	100	100	100	100	100	100	100	91	100	100	100
Rehabilitated	100	100	100	100	100	100	100	100	100	100	100	100
Restoration (physical or mental)												
Not rehabilitated	19	10	33	6	0	0	23	20	56	20	0	0
Rehabilitated	37	22	67	11	0	0	65	38	36	84	67	33
Income maintenance												
Not rehabilitated	23	15	11	22	10	0	19	28	28	30	0	0
Rehabilitated	35	28	24	16	14	0	30	37	45	15	33	100
Service in other family members												
Not rehabilitated	1	0	0	0	0	0	2	0	1	0	0	0
Rehabilitated	4	0	2	3	0	100	5	8	2	8	67	0
Other services												
Not rehabilitated	48	73	50	56	40	50	58	51	37	0	0	50
Rehabilitated	39	58	30	22	36	0	70	49	41	23	33	33
College or university												
Not rehabilitated	6	5	6	0	0	0	2	9	8	10	0	0
Rehabilitated	6	0	2	0	0	0	0	5	12	8	0	0
Other academic training (elementary or high school)												
Not rehabilitated	12	15	28	6	40	0	4	15	9	20	0	0
Rehabilitated	7	11	2	0	15	0	18	8	9	0	0	0
Business school												
Not rehabilitated	10	8	0	0	0	0	0	15	16	10	0	50
Rehabilitated	13	8	2	3	0	0	10	19	21	0	67	0
Vocational school												
Not rehabilitated	5	5	0	0	0	0	4	6	8	0	0	0
Rehabilitated	15	6	26	14	43	0	5	19	14	0	0	0
On-the-job training												
Not rehabilitated	6	0	0	11	10	0	4	0	10	10	0	0
Rehabilitated	13	6	0	23	50	0	15	3	14	15	0	0
Personal or vocational adjustment												
Not rehabilitated	51	25	50	50	40	100	39	63	60	0	100	0
Rehabilitated	75	81	72	84	100	100	85	70	65	85	100	100
Miscellaneous other training												
Not rehabilitated	5	0	0	0	0	0	4	4	6	0	0	0
Rehabilitated	13	0	7	14	43	100	5	8	17	8	0	33

SOURCE: Rand analysis of FY 1974 "Case Service Reports."

NOTE: NA = not applicable.

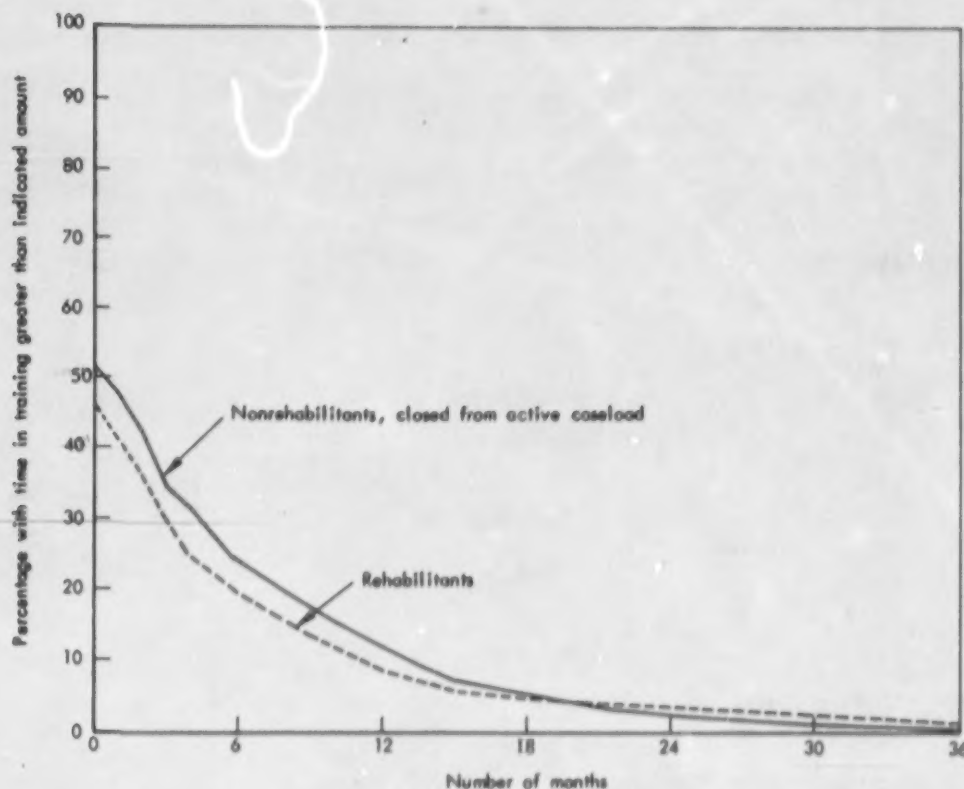


Fig. A.1—Time in training for mentally disabled VR clients, FY 1974 closures

individuals could receive more than one type, e.g., the same person might receive vocational adjustment, vocational school, and on-the-job training. However, from data on the total amount of time each client spent in training, we find that only about half (48 percent of rehabilitants and 52 percent of nonrehabilitants) had been in training for one or more months. Thus, about half the clients received little or no occupational training. As shown in Fig. A.1, about one-quarter of the clients (22 percent of rehabilitants and 28 percent of nonrehabilitants) were in training status for 6 or more months.

The Washoe Association for Retarded Citizens is currently expanding its program, primarily with public funds, so that it will serve more mentally retarded people as a vendor of services to the Bureau of VR.*

TIME SPENT IN VR PROGRAM

For mentally disabled FY 1974 rehabilitants, the median time between referral and acceptance for service was 2 months, and between acceptance and closure 8 to 10 months, for a total of 10 to 12 months. The half of the clients who received

* Interview with L. Hoover, Washoe ARC, Reno, Nevada, September 19, 1974.

training for one or more months spent a median time of 6 months in the training phase of the program. Nonrehabilitated clients closed from the active caseload spent about the same median amount of time getting into the program and being served. Clients who were closed not rehabilitated from an extended evaluation status spent about half as long in the program, a median of about 6 months. (See Table A.16.) Looking at the distribution of time spent in the program (see Fig. A.2), note that about one-fourth of the clients that were on the active caseload spent 6 months or less from referral to closure, while approximately one-fourth spent more than 18 months.

Table A.16

MEDIAN NUMBER OF MONTHS SPENT IN VR PROGRAM, FY 1974 CLOSURES

Disability	Median Months from Referral to Acceptance			Median Months from Referral to Closure		
	Rehab.	Not Rehab., Active Caseload	Not Rehab., Extended Evaluation	Rehab.	Not Rehab., Active Caseload	Not Rehab., Extended Evaluation
All mental disabilities combined	2	2	1	10-12	10-12	6
Alcoholism	1	1	<1	7-9	13-15	5
Drug addiction	1	1	1	7-9	5	6
MR, mild	3	2	3	13-15	10-12	7-9
MR, moderate	3	4	2	7-9	13-15	7-9
MR, severe	2	1	3	16-24	6	7-9
Psychotic	2	1	1	7-9	13-15	5
Psychoneurotic	2	2	2	10-12	10-12	5
Other mental disorder	2	2	1	10-12	10-12	6
Epilepsy	3	2	4	10-12	13-15	10-12
Cerebral palsy	1	2	NA	16-24	10-12	NA
Parkinson's disease	NA	NA	1	NA	NA	10-12
Strokes	2	3	3	6	25-36	16-24

SOURCE: Rand analysis of FY 1974 "Case Service Reports."

NOTE: NA = not applicable (no client in this category).

A comparison with national data shows Nevada to resemble the median state with respect to clients' times in the program. Nationally, in FY 1970, the median time from referral to acceptance for all types of VR clients was 2 months, median time from referral to closure was 13 months, 41 percent received one or more months of training, and the median time in training for those trained was 10 months.⁷

EARNINGS AND SOURCES OF SUPPORT

Family and friends were the most prevalent primary source of support at the

⁷ U.S. Department of Health, Education and Welfare, *Characteristics of Clients Rehabilitated in FY 1966-1970*, Publication No. (BRS) 72-25402, 1972, Table 17.

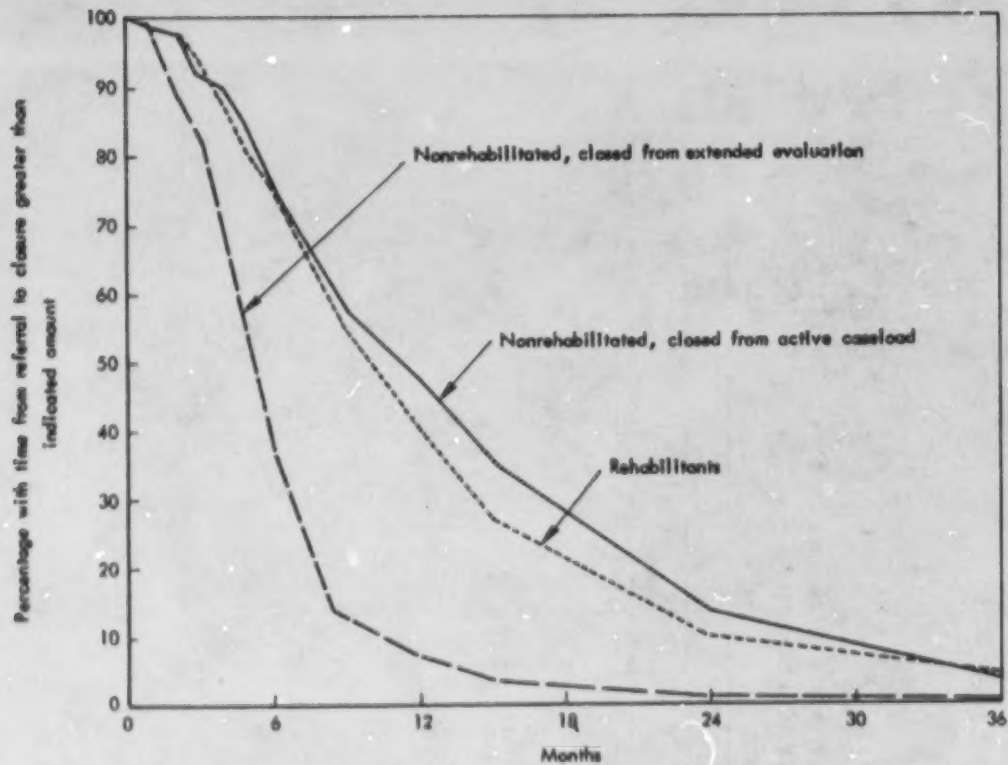


Fig. A.2—Time from referral to closure for mentally disabled VR clients, FY 1974 closures

time of application for mentally disabled VR clients whose cases were closed in FY 1974, accounting for nearly half of the cases. About one-fourth of the clients were primarily supported by a public tax-supported institution. Only about one in eight were primarily supported by their own current earnings. Also about one in eight was primarily supported by public or general assistance. Sources of support for rehabilitated and nonrehabilitated mentally disabled persons at the time of application were similarly distributed, except that nonrehabilitants were much more likely to be supported by a public tax-supported institution. In other terms, about one-third of the rehabilitants and about one-half of the nonrehabilitants were primarily publicly supported at the time of referral, and only a small fraction were primarily self-supported.

Looking across the types of mental disabilities, family and friends were the most prevalent primary source of support in all categories of disabled people except alcoholics and psychotics, who were most likely to be supported by a public tax-supported institution. (See Table A.17.)

Only 19 percent of the mentally disabled VR clients served were married, 65 percent had no dependents, and 21 percent had more than one dependent. The average family size for mentally disabled persons served was 2.8 persons; the family size was 1.0 for 34 percent of those served, 2.0 for 18 percent, 3.0 for 16 percent, and 4 or more for 32 percent.

Table A.17
SOURCE OF SUPPORT AT TIME OF APPLICATION FOR VR SERVICE, BY TYPE OF MENTAL DISABILITY, FY 1974 CLOSURES
(In percent)

Primary Source of Support	Client Rehabilitated												
	Client Not Rehabilitated; All Mental Disabilities Combined	All Mental Disabilities Combined	Alcoholism	Drug Addiction	MR, Mild	MR, Moderate	MR, Severe	Psychotic	Psychotic neurotic	Other Mental Disorder	Epilepsy	Cerebral Palsy	Stroke
Current earnings, interest, dividends, rent	6	17	14	30	6	0	0	10	27	19	8	0	0
Family and friends	44	47	31	48	76	71	100	20	43	39	85	100	100
Private relief agency	<1	1	6	0	3	0	0	0	0	0	0	0	0
Public assistance, at least partly with federal funds	9	13	0	4	8	14	0	5	8	25	8	0	0
General assistance only	<1	2	0	4	3	0	0	0	8	1	0	0	0
Public institution, tax-supported	34	14	47	2	3	0	0	60	8	9	0	0	0
Workmen's Compensation	1	2	0	4	3	0	0	5	0	2	0	0	0
Social Security Disability Insurance	<1	0	0	0	0	0	0	0	0	0	0	0	0
Other disability, sickness, survivor, or age retirement benefits (except private insurance); unemployment insurance benefits	3	3	3	7	0	14	0	0	5	2	0	0	0
Annuity and other nondisability insurance (private)	0	0	0	0	0	0	0	0	0	0	0	0	0
Disability or sickness benefits (private insurance); savings; other sources	1	1	0	0	0	0	0	0	0	3	0	0	0

SOURCE: Rand analysis of FY 1974 "Case Service Reports."
NOTE: Columns may not total to 100 because of rounding.

The median monthly family income of mentally disabled rehabilitants at time of referral was in the \$150 to \$199 range (or \$1800 to \$2388 per year); nearly half had incomes of less than \$150 per month. Only 19 percent had monthly incomes of \$600 or more (\$7200 or more per year). Nonrehabilitants' family incomes were even less: 62 percent had incomes of less than \$150 per month. The family income of mentally retarded rehabilitants at time of referral was somewhat higher but still low—in the \$350 to 399 range. (See Table A.18.)

Table A.18

MONTHLY FAMILY INCOME OF MENTALLY DISABLED PERSONS AT TIME OF REFERRAL,
FY 1974 CLOSURES
(In percent)

Item	Income Range (\$)										Range Containing Median Income ^a
	0- 149	150- 199	200- 249	250- 299	300- 349	350- 399	400- 449	450- 499	500- 599	600+	
Clients not rehabilitated:											
All mental disabilities combined	62	3	4	1	3	2	5	3	2	16	\$0-149
Clients rehabilitated:											
All mental disabilities combined	48	6	3	4	5	5	5	4	3	19	\$150-199
Alcoholism	64	3	3	3	11	3	3	3	0	8	\$0-149
Drug addiction	48	4	2	9	9	7	4	4	2	11	\$150-199
MR, mild	39	3	3	0	3	6	3	3	0	42	\$350-399
MR, moderate	29	0	7	7	0	7	0	14	0	36	\$350-399
MR, severe	0	0	0	0	0	0	100	0	0	0	\$400-449
Psychotic	55	5	0	0	0	5	5	15	0	15	\$0-149
Psychoneurotic	42	6	3	11	8	6	3	3	6	14	\$200-249
Other mental disorder	49	10	4	2	3	2	8	3	5	16	\$150-199
Epilepsy	31	0	0	0	0	23	0	0	8	39	\$350-399
Cerebral palsy	33	0	0	0	0	0	0	0	0	67	\$600+
Stroke	100	0	0	0	0	0	0	0	0	0	\$0-149

SOURCE: Rand analysis of FY 1974 "Case Service Reports."

NOTE: Rows may not total to 100 because of rounding.

^aHalf the people have the median income or more.

Although 15 percent of the mentally disabled people who were rehabilitated in FY 1974 listed public or general assistance as their primary source of support at the time of referral, a larger fraction, 23 percent, were receiving some public or general assistance. The comparable figures for nonrehabilitants were 10 and 16 percent, respectively. Note that many of the residents in public tax-supported facilities are supported by the government but not on a public assistance program. As shown in Table A.19, Aid to Dependent Children (ADC) was the most prevalent type of public assistance received. Since the new Supplementary Security Income (SSI) public assistance program is being implemented, and Nevada did not have one of the SSI predecessor public assistance programs—Aid to the Permanently and Totally Disabled (APTD)—the fraction of referrals on public assistance should rise somewhat in

Table A.19
MENTALLY DISABLED CLIENTS RECEIVING PUBLIC ASSISTANCE, FY 1974
(In percent)

Client Group and Time	Not Receiving Public Assistance	ADC Only	General Assistance Only	ADC in Combination with Other Types of Assistance	Public Assistance Between VR Referral and Closure Only
Clients not rehabilitated:					
All mental disabilities combined					
Referral	84	6	3	6	NA
Closure	90	6	3	2	4
Clients rehabilitated:					
All mental disabilities combined					
Referral	77	13	4	7	NA
Closure	99	<1	<1	0	8
Alcoholism					
Referral	100	0	0	0	NA
Closure	100	0	0	0	0
Drug addiction					
Referral	89	4	7	0	NA
Closure	100	0	0	0	0
MR, mild					
Referral	89	8	3	0	NA
Closure	100	0	0	0	0
MR, moderate					
Referral	86	7	0	7	NA
Closure	100	0	0	0	0
MR, severe					
Referral	100	0	0	0	NA
Closure	100	0	0	0	0
Psychotic					
Referral	85	5	5	5	NA
Closure	100	0	0	0	10
Psychoneurotic					
Referral	70	19	5	5	NA
Closure	94	3	3	0	14
Other mental disorder					
Referral	60	23	3	15	NA
Closure	98	2	0	0	14
Epilepsy					
Referral	85	15	0	0	NA
Closure	100	0	0	0	8
Cerebral palsy					
Referral	100	0	0	0	NA
Closure	100	0	0	0	0
Stroke					
Referral	67	0	33	0	NA
Closure	100	0	0	0	33

SOURCE: Rand analysis of FY 1974 "Case Service Reports."

NOTES: NA = not applicable. Rows may not total to 100 because of rounding.

the future.* The median amount of public assistance for those receiving it at time of referral was in the \$100 to \$149 range per month. The median time on public assistance was less than 6 months; only 17 people had received assistance for more than two years. At the time of case closure, only about one percent of the mentally disabled rehabilitants were on public assistance, down markedly from 23 percent at the time of referral. Looking at the results by type of mental disability, the category of "other mental disorder" of character, behavior, or personality had the highest percentage on public assistance at time of referral, 40 percent, but improved to only 2 percent at time of closure. Comparable figures from referral to closure for other groups are: mentally retarded, 12 to 0 percent; psychotic, 15 to 0 percent; and psychoneurotic, 30 to 6 percent. In addition, at the time of referral, 3 percent of the mentally disabled clients had been allowed benefits under Social Security Disability Insurance (SSDI) and another 2 percent had applications for SSDI pending. (See Table A.20.)

Table A.20

PERCENTAGES OF CLIENTS IN SSDI STATUS CATEGORIES
AT TIME OF REFERRAL, FY 1974 CLOSURES

Social Security Disability Insurance Status	Clients Not Rehabilitated	Clients Rehabilitated
Not an applicant	91	96
Applicant, allowed benefits	5	1
Applicant, denied benefits	1	2
Application pending	3	1
Benefits discontinued or terminated	<1	0
Total	100	100

SOURCE: Rand analysis of FY 1974 "Case Service Reports."

NOTE: Columns may not total to 100 because of rounding.

Ten percent of the mentally disabled nonrehabilitants and 22 percent of the rehabilitants were gainfully employed at time of referral. Of mentally disabled rehabilitants, for example, 18 percent were employed in the competitive labor market, 2 percent were homemakers, and another 2 percent were either in sheltered workshops or were self-employed, or were unpaid family workers. At time of referral, rehabilitants who were not gainfully employed were either not working (70 percent), or were students (8 percent) or trainees (2 percent). At time of closure, all rehabilitants were gainfully employed: 88 percent in the competitive labor market; 2 percent in sheltered workshops (primarily mentally retarded people); 3 percent were self-employed; 6 percent were homemakers; and the remaining 1 percent were unpaid family workers. As shown in Table A.21, which gives a breakdown of the work status of each category of mentally disabled persons at time of referral and

* In 1970, for example, nationally there was one vocationally rehabilitated person on APTD at referral for approximately every four on ADC. *Characteristics of Clients Rehabilitated in FY 1966-1970*, DHEW Publication No (SRS) 72-25402, 1972.

Table A.21

PERCENTAGES OF MENTALLY DISABLED CLIENTS IN VARIOUS WORK STATUS CATEGORIES, FY 1974 CLOSURES

Client Group and Time	Competitive Labor Market	Sheltered Workshop	Self-Employed	Home-maker	Unpaid Family Worker	Not Working, Student	Not Working, Other	Trainee or Worker (Non-competitive Labor Market)
Rehabilitants:								
All mental disabilities combined								
Referral	18	<1	<1	2	<1	8	70	2
Closure	88	2	3	6	1	0	0	0
Alcoholism								
Referral	14	0	0	0	0	0	86	0
Closure	97	0	0	3	0	0	0	0
Drug addiction								
Referral	35	0	0	4	0	4	57	0
Closure	91	0	2	4	2	0	0	0
MR, mild								
Referral	8	3	0	0	3	35	49	3
Closure	81	5	5	5	3	0	0	0
MR, moderate								
Referral	0	0	0	0	0	0	79	21
Closure	79	21	0	0	0	0	0	0
MR, severe								
Referral	0	0	0	0	0	0	0	100
Closure	0	100	0	0	0	0	0	0
Psychotic								
Referral	10	0	5	0	0	0	85	0
Closure	85	5	5	0	5	0	0	0
Psychoneurotic								
Referral	22	0	0	5	0	3	70	0
Closure	84	0	5	11	0	0	0	0
Other mental disorder								
Referral	19	0	0	1	0	6	74	1
Closure	90	0	2	7	0	0	0	0
Epilepsy								
Referral	15	0	0	8	0	8	69	0
Closure	85	0	0	15	0	0	0	0
Cerebral palsy								
Referral	0	0	0	0	0	33	67	0
Closure	67	0	0	0	33	0	0	0
Stroke								
Referral	0	0	0	0	0	0	100	0
Closure	100	0	0	0	0	0	0	0
Nonrehabilitants:								
All mental disabilities combined								
Referral	6	<1	<1	1	0	5	85	<1
Closure	NA	NA	NA	NA	NA	NA	NA	NA

SOURCE: Rand analysis of FY 1974 "Case Service Reports."

NOTES: NA = data unavailable for majority of nonrehabilitants at time of closure. Rows may not total to 100 because of rounding.

closure, the lowest percentage of any of the more prevalent disabilities placed into competitive employment was a very commendable 79 percent for the moderately retarded.

Average reported weekly earnings for mentally disabled rehabilitants rose from \$19 at the time of referral to \$105 at the time of closure. The percentage with no earnings dropped from 79 percent at the time of referral to 7 percent at the time of closure (some rehabilitants, such as homemakers and unpaid family workers, are considered gainfully employed with no income). The highest-earning people at time of closure were rehabilitated alcoholics (\$137/week) and the lowest-earning were the severely retarded (less than \$40/week). See Table A.22 for the breakdown of earnings by type of mental disability. As shown in Fig. A.3, only about two-thirds of the mentally disabled rehabilitants at time of closure earned more than \$80 per week—the 1974 minimum wage of \$2 an hour for a 40-hour week—and only 4 percent earned more than \$200 per week. Thus, rehabilitants were being placed in relative/low-paying positions. For comparison, the national average weekly earnings of production or nonsupervisory workers on private nonagricultural payrolls in March 1974 were \$149.⁹

In aggregate terms, the estimated annualized earnings, based on weekly earnings of all mentally disabled people rehabilitated in FY 1974, rose from approximately \$330,000 at time of referral to approximately \$1,820,000 at time of closure.

OCCUPATIONS OF REHABILITANTS

As shown in Table A.23, the majority of rehabilitated mentally disabled persons are placed into jobs in the service, clerical, or sales fields; 10 percent are placed in professional, technical, or managerial positions; 6 percent become homemakers; only 2 percent are placed into sheltered workshops; and few (2 percent) are placed into farming, fishing, or forestry.¹⁰

⁹ *Employment and Earnings*, Bureau of Labor Statistics, U.S. Department of Labor, Vol. 20, No. 11, p. 93, May 1974.

¹⁰ See the *Dictionary of Occupational Titles*, Bureau of Employment Security, U.S. Department of Labor, 3d ed., Vol. 1, 1966, for definitions of the specific types of occupations included in the various categories in Table A.23.

Table A.22
WEEKLY EARNINGS OF VR CLIENTS, FY 1974 CLOSURES

Client Group and Time	Percentage in Weekly Earnings Range									Average Weekly Earnings ^a
	\$0	\$1-39	\$40-64	\$65-80	\$81-99	\$100-149	\$150-199	\$200-299	\$300+	
Rehabilitants:										
All mental disabilities combined										
Referral	79	4	5	5	1	5	1	<1	<1	\$19
Closure	7	5	6	18	12	42	7	4	<1	\$105
Alcoholism										
Referral	86	0	6	0	3	3	0	3	0	\$17
Closure	3	0	0	14	8	50	11	11	3	\$137
Drug addiction										
Referral	65	2	11	9	2	7	2	0	2	\$34
Closure	7	0	4	13	7	50	9	11	0	\$124
MR, mild										
Referral	89	5	0	3	0	0	0	0	3	\$14
Closure	8	19	16	19	14	24	0	0	0	\$69
MR, moderate										
Referral	86	14	0	0	0	0	0	0	0	\$3
Closure	0	21	14	50	0	14	0	0	0	\$65
MR, severe										
Referral	0	100	0	0	0	0	0	0	0	\$20
Closure	0	100	0	0	0	0	0	0	0	\$20
Psychotic										
Referral	85	0	0	0	0	15	0	0	0	\$19
Closure	5	5	5	20	15	45	0	5	0	\$100
Psychoneurotic										
Referral	73	3	8	11	3	3	0	0	0	\$19
Closure	11	5	3	22	16	41	0	3	0	\$92
Other mental disorder										
Referral	78	4	3	7	1	6	2	0	0	\$19
Closure	7	1	5	15	15	45	11	1	1	\$109
Epilepsy										
Referral	85	8	8	0	0	0	0	0	0	\$6
Closure	15	0	8	23	8	39	8	0	0	\$91
Cerebral palsy										
Referral	100	0	0	0	0	0	0	0	0	\$0
Closure	33	0	0	33	33	0	0	0	0	\$54
Stroke										
Referral	100	0	0	0	0	0	0	0	0	\$0
Closure	0	0	0	0	0	67	33	0	0	\$142
Nonrehabilitants:										
All mental disabilities combined										
Referral	92	2	2	2	<1	<1	<1	<1	0	\$6
Closure	NA	NA	NA	NA	NA	NA	NA	NA	NA	

SOURCE: Rand analysis of FY 1974 "Case Service Reports."

NOTES: NA = not available for majority of nonrehabilitants at time of closure. Percentages may not total to 100 because of rounding.

^aThe average was calculated assuming the average earnings within each income range was the mid-point of that range, except for the \$300+ range, where \$350 was arbitrarily assumed to be the intra-range average.

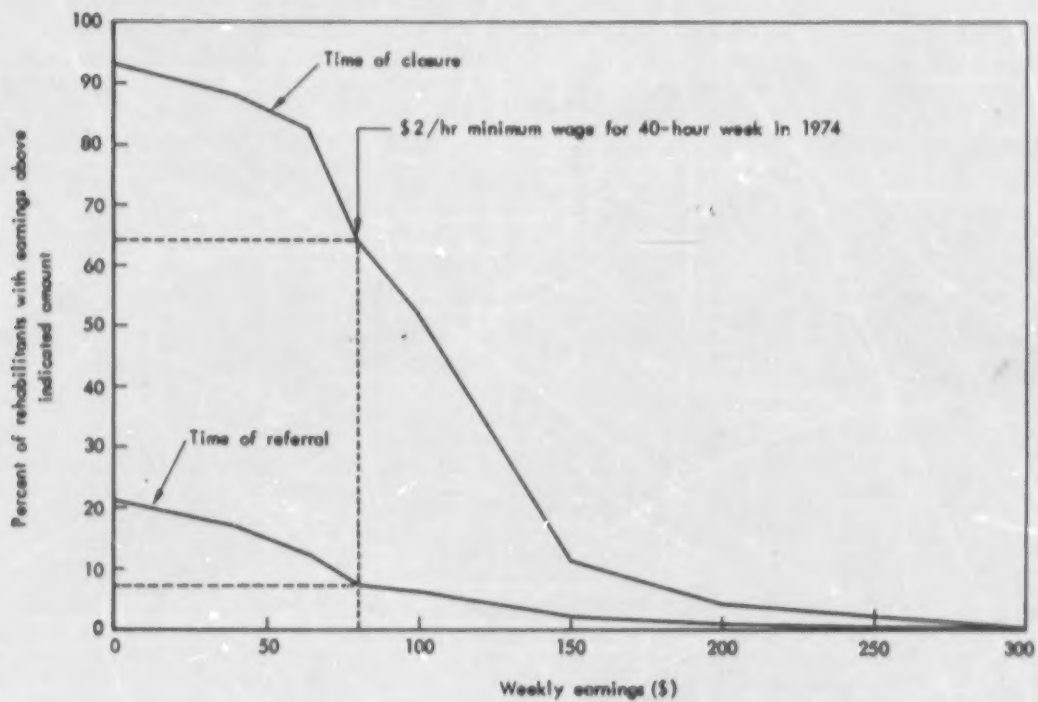


Fig. A.3—Weekly earnings of mentally disabled rehabilitants, FY 1974 closures

Table A.23
PERCENTAGES OF REHABILITATED VR CLIENTS IN VARIOUS OCCUPATIONS, FY 1974
CLOSURES

Occupation	Disability Group										All Mental Disabilities Combined	
	Alcoholism	Drug Addiction	MR, Mild	MR, Moderate	MR, Severe	Psychosis	Psychoneurotic	Other Mental Disorder	Epilepsy	Cerebral Palsy		Stroke
Professional, technical, managerial	17	11	0	0	0	10	14	11	15	0	33	10
Clerical, sales	22	17	5	0	0	10	38	28	15	33	33	22
Service	25	41	68	71	0	60	24	33	39	33	0	39
Farming, fishing, forestry	0	7	5	0	0	5	0	0	8	0	0	2
Processing	3	7	0	0	0	5	0	3	0	0	0	2
Machine trades	0	2	0	0	0	0	0	3	0	0	0	2
Beach work	11	0	5	7	0	0	5	7	0	0	0	5
Structural work	3	4	0	0	0	5	3	2	8	33	33	4
Homemaker	3	4	5	0	0	0	11	7	15	0	0	6
Sheltered workshop	0	0	5	21	100	5	0	0	0	0	0	2
Unpaid family worker	0	2	0	0	0	0	0	0	0	0	0	<1
Miscellaneous	11	4	5	0	0	0	5	7	0	0	0	5

SOURCE: Rand analysis of FY 1974 "Case Service Reports."

NOTE: Columns may not total to 100 because of rounding.

Appendix B

JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

SURVEYS OF THE NEVADA MENTAL HEALTH INSTITUTE

**Joint
Commission**
on Accreditation of Hospitals

875 North Michigan Avenue Chicago, Illinois 60611

March 16, 1973

Victor J. LoCicero, M.D.
Superintendent
Nevada State Hospital
Box 1460
Reno, Nevada 89411

John D. Porterfield, M.D.
Director (312) 642-6061

Dear Doctor LoCicero:

The Board of Commissioners of the Joint Commission on Accreditation of Hospitals upon the recommendation of the Accreditation Council for Psychiatric Facilities, has approved the recommendation that your facility be accredited for a period of two years or until a subsequent survey is conducted. This is the result of the survey of the facility conducted on Jan. 30, 31 and Feb. 1, 1973 by the field representative of the Accreditation Council for Psychiatric Facilities. Accreditation is effective as of the date of approval by the Board of Commissioners, i.e., March 16, 1973.

Attached are the recommendations for the improvement of the quality of patient care based on the findings of the survey. These warrant your attention and should be put into effect without delay.

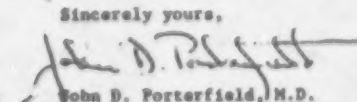
Copies of this letter with a report of the recommendations have been sent to the head of the governing body and the chief of the medical staff of your facility. Since this report itself is confidential on the part of the Commission, the release of its contents is a matter for your mutual consideration and decision. Any publicity emanating from this report must of necessity come from your authorized spokesman.

Your facility is entitled to a Certificate of Accreditation. To be certain that our information is correct, we ask that you please complete and return the enclosed form.

If any question should arise relating to this letter or to the accreditation status of your facility, please communicate with Jack W. White, D.B.A., Program Director, Accreditation Council for Psychiatric Facilities, Joint Commission on Accreditation of Hospitals.

The Commission wishes to commend you for maintaining standards deserving of accreditation and for your constant effort to improve the quality of patient care. Please be assured of our interest and of our willingness to be of all possible help to you.

Sincerely yours,


John D. Porterfield, M.D.
Director

cc: Mr. Roger S. Tronday, Chairman of the Governing Body



Albany College of Arts and Sciences

Albany College of Arts and Sciences

Albany College of Arts and Sciences

Albany College of Arts and Sciences

Albany College of Arts and Sciences

Joint Commission 875 North Michigan Avenue Chicago, Illinois 60611
 on Accreditation of Hospitals
 Accreditation Council for Psychiatric Facilities

March 16, 1973

Jack W. White, D.B.A.
 Program Director (312) 642-6061

Victor J. LoCicero, M.D.
 Superintendent
 Nevada State Hospital
 Box 2460
 Reno, Nevada 89431

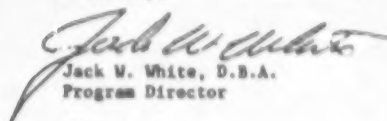
Dear Doctor LoCicero:

The Accreditation Committee of the Accreditation Council for Psychiatric Facilities was pleased to have the opportunity to recommend that Nevada State Hospital receive accreditation for a period of two years. The Committee gave careful consideration to this matter and has directed that you be notified of an important point relative to the accreditation status of your facility:

According to Joint Commission policy, if an accreditation program recommends one-year accreditation or non-accreditation for one category of service, no other category of service shall receive more than one-year accreditation. Consequently, if the survey of the retardation service of your facility were to result in less than two-year accreditation for that service, then the period of accreditation for the entire facility would be reduced to one year.

We trust that your accreditation survey will be a positive influence in the provision of quality services to your patients and look forward to working with you in every way possible toward our common goal of serving the mentally ill.

Sincerely,


 Jack W. White, D.B.A.
 Program Director

JW:mu

cc: Mr. Roger S. Trounaday, Chairman of the Governing Body

Council Members
 American Academy of Child Psychiatry
 American Hospital Association
 American Psychiatric Association

American Association on Mental Deficiency
 National Association of Private Psychiatric Hospitals
 National Association of State Mental Health Program Directors
 National Council of Community Mental Health Centers, Inc.

NEVADA STATE HOSPITAL
RENO, NEVADA

Outpatient Services

1. There should be a written plan describing the arrangements for the provision of outpatient services to meet the needs of patients.

Partial Hospitalization Services

1. There should be a written plan describing the arrangements for the provision of partial hospitalization services to meet the needs of patients.

Volunteer Services

1. The volunteer services should make a written report to the administration annually.

PARTICULAR ATTENTION IS DRAWN TO THE MAJOR DEFICIENCIES OUTLINED ABOVE IN SECTIONS:

MEDICAL RECORDS
PSYCHOLOGICAL SERVICES

THESE AND OTHER DEFICIENCIES MUST BE CORRECTED IN ORDER THAT ACCREDITATION MAY BE MAINTAINED.

FOR A FULLER UNDERSTANDING OF THESE RECOMMENDATIONS, REFERENCE SHOULD BE MADE TO:

ACCREDITATION MANUAL FOR PSYCHIATRIC FACILITIES

RATING BY BOARD OF COMMISSIONERS: ACCREDITATION FOR TWO YEARS

NEVADA STATE HOSPITAL
RENO, NEVADA

DATE OF SURVEY
JAN. 31 & FEB. 2, 1973

SURVEYOR
NORMAN C. MACE, M.D.

REVIEWERS
JACK W. WHITE, D.S.A.
JOHN MULHEARN

RECOMMENDATIONS AND COMMENTS

Environmental Services

1. In buildings housing patients all toilets should have doors for individual privacy.

Medical Records

1. The mental status examination for each patient should be more fully documented in the medical records.

Activity Program Services

1. Staff of the activity program services should be increased in number to effect a better delivery of these services to patients.

Dietetic Services

1. The dietitian or appropriate person should participate in clinical rounds and conferences.

Psychological Services

1. There should be a written plan describing the organization of psychological services.
2. The personnel of psychological services should participate in administrative and clinical committees and conferences.
3. There should be written policies and procedures for the provision of psychological services.
4. Minutes should be kept of all meetings of the psychological services staff.
5. Necessary statistical records should be maintained for planning and evaluating psychological services.
6. In addition, the functions of the psychological services should be implemented according to the standards in the Accreditation Manual for Psychiatric Facilities.

Joint Commission 875 North Michigan Avenue Chicago, Illinois 60611
 on Accreditation of Hospitals
 Accreditation Council for Psychiatric Facilities

March 21, 1974

Jack W. White, D.B.A.
 Program Director (312) 642-6061

Victor J. LoCicero, M.D.
 Superintendent
 Nevada Mental Health Institute
 Box 2460
 Reno, Nevada 89431

Dear Doctor LoCicero:

As you will recall, at the time of the JCAH Board of Commissioners' decision to accredit Nevada Mental Health Institute for two years, the Accreditation Committee of the Accreditation Council for Psychiatric Facilities also made known to you the Joint Commission's policy of granting no more than one year accreditation to a facility if one of the other categories of service receives less than two year accreditation. Since the mental retardation unit of Nevada Mental Health Institute received non-accreditation at the meeting March 15, 1974 of the Board of Commissioners, it is necessary to reduce the term of accreditation from two years to one year.

Enclosed are recommendations for bringing your facility into compliance with the standards of the Accreditation Council for Facilities for the Mentally Retarded. AC/FMR is anxious to give you all possible assistance in your efforts to improve the services that your facility provides its residents. If you have any questions concerning the survey of the mental retardation unit, please communicate with Kenneth G. Crosby, Ed.D., Program Director, Accreditation Council for Facilities for the Mentally Retarded.

We are pleased to have the opportunity to survey Nevada Mental Health Institute and look forward to your continued interest in our program.

Sincerely,



J.H. St. Louis, FACMA
 Division Director
 Psychiatric Hospitals Division

JHS:dd
 Enclosure

cc: Mr. Roger S. Trounaday, Chairman of the Governing Body



Council Members
 American Academy of Child Psychiatry
 American Hospital Association
 American Psychiatric Association

American Association on Mental Deficiency
 National Association of Private Psychiatric Hospitals
 National Association of State Mental Health Program Directors
 National Council of Community Mental Health Centers, Inc.

182073

MENTAL RETARDATION PROGRAM
NEVADA MENTAL HEALTH INSTITUTE
RENO, NEVADA

DATES OF SURVEY
 NOVEMBER 8, 9, 12, 1973

SURVEYOR
 Cooper L. Farnetti, Ph.D.

RECOMMENDATIONS AND COMMENTS

REMARKS
REFERRED TO

1. Administrative Policies and Practices

- | | |
|---|------------------------|
| 1. The grouping of programs and residence units should be based upon a rational plan which includes smaller groupings of residents of comparable developmental level. | 1.1.5.1* |
| 2. The facility's role in the state's program for the mentally retarded should be made clear to consumer representatives, the interested public, and the facility's own staff. | 1.2.1.1* |
| 3. The facility should have a written statement of policies and procedures that protect the financial interests of residents. This policy should assure that residents receive the funds for incidentals and special needs that are due them under public and private financial support programs. | 1.2.2.2*
1.2.2.2.2* |
| 4. Administrative policy and procedure should provide for effective channels of communication in all directions. | 1.2.8.1.5 |
| 5. The facility should have a description of services for residents that is available to the public. | 1.2.10* |

1.3 Admission and Release

- | | |
|---|--|
| 6. The facility should not admit residents whose needs it cannot meet, and the number of residents admitted to the facility should not exceed its provisions for adequate programming. | 1.3.1*
1.3.1.1.2* |
| 7. The facility should admit only those residents who have had a comprehensive evaluation conducted by an appropriately constituted interdisciplinary team. The evaluation should identify the services needed by the resident, whether or not these are presently or immediately available. All available and applicable programs of care should then be investigated and the findings recorded. Admission to the facility should occur only when it is determined to be the optimal available plan. When admission is not considered optimal, but must nevertheless be implemented, its inappropriateness should be clearly acknowledged and documented, and plans for the continued exploration of alternatives should be initiated. | 1.3.3*
1.3.3.1
1.3.3.2*
1.3.3.3*
1.3.3.4 |

Survey Report

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8. All admissions to the facility should be considered temporary, for the express purpose of meeting the resident's defined needs. Admissions should be time-limited when appropriate. 1.3.3.6*
9. Within the period of one month after admission, there should be such review and updating of the preadmission evaluation as is necessary in order to bring all information up-to-date. The updating should include a behavioral prognosis that can be used for programming and placement; that is, a statement of the specific goals of the resident's habilitation program, stated in behavioral terms, with a statement of the time frame within which it is expected or hoped that they can be achieved, and with a statement of the time at which the resident's progress toward the goals will be reviewed and the goals reevaluated. 1.3.3.1*
1.3.3.2*
10. The review and updating should result in a comprehensive evaluation and individual program plan devised by an interdisciplinary team that includes participation by the direct-care staff who are responsible for implementing the resident's day-to-day program. The results should be recorded in the resident's unit record, and their interpretation, in action terms, to both direct-care and special services personnel should be documented. The interpretation of the evaluation and plan to the resident's parents should also be documented. 1.3.3.3*
1.3.3.4
1.3.3.5*
1.3.3.6.1*
1.3.3.6.2*
1.3.3.6.3*
11. There must be at least an annual joint review of the status of each resident by all relevant personnel, including direct-care personnel. This review must result in specific and detailed program recommendations. At the time of the resident's attaining majority, there must be documented specific consideration of the resident's need for remaining in the facility. The need for guardianship of the resident, and the exercise of his civil and legal rights, should also be reviewed at this time. 1.3.6*
1.3.6.2.1*
1.3.6.2.2*
1.3.6.2.3*
12. The results of the joint review must be recorded in the resident's unit record, made available to all relevant personnel, interpreted to the resident's parents, and, whenever appropriate, interpreted to the resident himself. 1.3.6.3.1*
1.3.6.3.2*
1.3.6.3.3*
1.3.6.3.4*

1.4 Personnel Policies

13. Staffing of the facility should be sufficient, so that the facility is not dependent upon the use of resident, volunteers, or foster grandparents for productive services. 1.4.6*
14. The facility should have a written policy to protect residents from exploitation when they are engaged in productive work. The facility should also have a current written policy encouraging the training of residents for productive, paid employment. Residents who function as staff should be paid at the legally required wage level. 1.4.6.1*
1.4.6.7*
1.4.6.4.2*

Survey Report

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15. The facility should have an active and appropriate staff training program that includes induction training for each new employee and continued inservice training for all employees. 1.4.7*
1.4.7.2*
1.4.7.3*

2. Resident Living2.1 Staff-Resident Relationships and Activities

16. Living unit personnel should be more involved in the training of residents in activities of daily living and self-help skills. The living environment for the residents should be warm and home-like, so as to be conducive to achievement and development. Living unit personnel should not be diverted from their primary responsibility for resident care and development by excessive housekeeping and clerical duties. 2.1.1.2*
2.1.1.3*
2.1.1.4*
17. Because shuffling of personnel from one living unit to another is not conducive to the development of consistent inter-personal relationships between residents and members of the living unit staff, there should be reasonable stability in the assignment of living unit personnel to particular living units. 2.1.1.5*
18. There should be appropriately constituted interdisciplinary teams to generate specific evaluation and program plans for each resident. Each team should include representatives of those professions, disciplines, or services that are relevant to the particular resident being considered, as well as the direct-care staff who are responsible for carrying out his day-to-day plan. 2.1.2.1*
3.1.2.1*
19. The specific evaluation and program plan for each resident should be available to the direct-care staff in the living unit and reviewed by a member of the interdisciplinary team at least monthly. 2.1.2.1.1*
2.1.2.1.2*
20. An activity schedule for each resident should be available to direct-care staff and should be implemented daily. No schedule should permit dead time of unscheduled activity for more than one hour continuous duration. 2.1.2.2*
2.1.2.2.1
21. Multiply handicapped and nonambulatory residents should spend a portion of their waking day out of their bedroom areas, and should have planned activity and exercise periods daily. 2.1.3.2.2*
2.1.3.2.3*
22. Birthdays and other special events should be celebrated individually. 2.1.3.5
23. Residents should be trained in the value and the use of money. 2.1.7.1.2*
24. There should be provisions for prompt recognition and appropriate management of behavioral problems in the living unit. There should be a written statement of policies and procedures for the control and discipline of residents that are directed to the goal of maximizing their growth and development. These policies should be available in each living unit and should be made available to parents or guardians. 2.1.8*
2.1.8.1*
2.1.8.1.1*
2.1.8.1.2*
2.1.8.1.3*

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25. Chemical restraint should not be used excessively. When chemical restraint is used there must be evidence in the program plan of a prescription by a physician, a treatment objective stated in specific terms, the temporary nature of the prescription, and data reflecting the progress or regress of the resident with regard to the treatment objective. 2.1.8.8*
26. Behavior modification programs involving the elimination of mal-adaptive behaviors by means of noxious or aversive stimuli must be approved by an appropriately constituted human rights committee. Such programs may be conducted only with the consent of the resident's parents or guardians, and they must be described in written plans that are kept on file in the facility. 2.1.8.9.1*
2.1.8.9.2*
2.1.8.9.3*
- 2.2 Food Services
27. Modified diets should be prescribed by the resident's program team, with a record of the prescription kept on file. 2.2.2.1.1*
28. Dining areas should be pleasant and home-like. 2.2.3.2.3
29. Residents should be provided with systematic training to develop appropriate eating skills. Direct care staff should be trained in the utilization of proper feeding techniques. 2.2.4
2.2.4.2
- 2.3 Clothing
30. Residents should be trained to select and purchase their own clothing, to select their daily clothing, and to dress themselves. 2.3.2.1
2.3.2.2
2.3.2.3
31. Adequate storage space for clothing to which the resident has access should be provided. 2.3.3*
- 2.4 Health, Hygiene, and Grooming
32. All residents should be assisted in learning normal grooming practices. 2.4.1.1*
33. Residents' bathing should be conducted at the most independent level possible, and with due regard for privacy. 2.4.1.5.1*
2.4.1.5.2*
34. All residents who do not eliminate appropriately and independently should be engaged in a toilet training program. Records should be kept of the progress of each resident receiving toilet training. 2.4.2
2.4.2.4
35. Residents should be taught to use properly adapted drinking units. 2.4.3.1*

Survey Report

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2.5 Grouping and Organization of Living Units

36. Living unit groupings should be small enough to ensure meaningful interpersonal relationships among residents and staff. 2.5.1*
37. Residents with special disabilities should be integrated with peers with comparable social and intellectual development. 2.5.2.2*
38. Residents should be allowed free use of all living areas within the living unit. 2.5.4*

2.6 Resident-Living Staff

39. There should be sufficient personnel to conduct the living unit programs in accordance with the standards. 2.6.1*

2.7 Design and Equipage of Living Units

40. The design, construction, and furnishing of resident living units should be appropriate to the program. Furnishings should be comfortable and home-like. 2.7.1.2
2.7.2.3*
41. Each resident should be provided with appropriate individual furniture, and each should have a place for his own personal play equipment and prosthetic devices. 2.7.3.9.1*
2.7.3.9.2*
42. Water closets, showers, bath tubs, and lavatories should approximate normal patterns found in homes, and they should provide for individual privacy. 2.7.5.1
2.7.5.2*

3. Professional and Special Programs and Services

43. In addition to adequate resident living services, residents must also be provided with the professional and special programs that they need. 3.1.1*
44. Whenever possible, professional services available in the community should be utilized, and the quality of such services must conform to the standards. The facility should require that services meet the Standards, and contracts for the provision of services should stipulate that the Standards will be met. 3.1.1.2*
3.1.1.3*
3.1.1.3.1*
45. Services delivered to residents should reflect cooperative, coordinated, and interdisciplinary planning and implementation. There should be a comprehensive diagnosis and evaluation of each resident, as a basis for program planning and management. 3.1.2.3*
3.1.3.1*

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Survey Report

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3.2 Dental Services

46. A copy of the permanent dental record should be provided the facility to which a resident is transferred.

3.2.8.2*

3.3 Educational Services

47. Educational services should be made available to all residents. Individual educational programs should be implemented in a systematic fashion to meet the identified needs of residents, including those with special disabilities.

3.3.1*
3.3.2.1*
3.3.7.3*
3.3.7.4*

48. There should be a written statement of educational objectives that are consistent with the facility's philosophy and goals. There should be appropriate programs to implement the facility's educational objectives.

3.3.1.1*
3.3.7*

49. An educator should be a member of the interdisciplinary team concerned with the total programming of each resident, and with the planning and development of the facility's programs for residents.

3.3.3.1*
3.3.3.2*

50. Individual educational evaluations should commence with the admission of the resident. These evaluations should be conducted at least annually, should be based upon the use of empirically reliable and valid instruments, should provide the basis for prescribing an appropriate program for the resident, and for revising the individual program as needed. Evaluation results should be reported and disseminated in such a fashion as to facilitate understanding and implementation, and they should provide information that is useful to staff working directly with the resident.

3.3.4.1*
3.3.4.2*
3.3.4.3*
3.3.4.4*
3.3.4.5*
3.3.4.6.1*
3.3.4.6.2*

51. There should be written educational objectives for each resident, and educational activities designed to meet the objectives set.

3.3.5*
3.3.6*

52. Educational programs in the facility should be comparable to similar programs for students in the community. Opportunities for physical education, health education, music, and art education should be provided.

3.3.7.2*
3.3.7.3*

53. There should be sufficient, appropriately qualified educational personnel to carry out the facility's education program in an adequate fashion.

3.3.8*

3.4 Food and Nutrition Services

54. Food and nutrition service personnel should participate in the interdisciplinary evaluation of individual residents as needed.

3.4.3.5

Survey Report

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3.6 Medical Services

55. Physicians should participate, when appropriate, in the continuing interdisciplinary evaluation of residents. 3.6.5.1*
56. Medical management plans should include the resident's day to day activity program, provisions for physical rehabilitation to prevent and correct deformity, to enhance mobility and to facilitate training in self-help skills, and provisions for adaptive equipment necessary to the rehabilitation plan. Each plan should include short- and long-term goals, including criteria for release, together with a statement of the intervals at which it is to be reviewed. Goals and plans should be reviewed and up-dated as needed, but at least annually, so as to assure the continuing appropriateness of the goals and the resident's achievement of progress toward them. 3.6.6.1*
3.6.6.2*
3.6.6.3*
3.6.6.6*
3.6.6.7*
3.6.7.1*
3.6.7.2*
57. Annual physical examinations should include functional examinations of vision and hearing. 3.6.9.2.1

3.7 Nursing Services

58. There should be a written statement of nursing philosophy and objectives that are consistent with the purposes of the facility. Nursing personnel should be responsible for the formulation of this policy, and it should be distributed to all nursing personnel. 3.7.2*
3.7.2.1*
3.7.2.2.1*

3.8 Pharmacy Services

59. Upon the admission of a resident, a medication history of prescription and non-prescription drugs used should be obtained and entered into his record. 3.8.2*

3.9 Occupational Therapy Services

60. The facility's statement of occupational therapy objectives should be consistent with the needs of its residents. 3.9.1.2.1*
61. Occupational therapists should participate, when appropriate, in the interdisciplinary evaluation of residents. 3.9.4.4*

3.9 Physical Therapy Services

62. Sufficient physical therapy services should be provided to facilitate the optimal development of each resident. Physical therapists should participate, when appropriate, in the interdisciplinary evaluation of residents, and physical therapists should have the responsibility for organizing and implementing programs to achieve physical therapy goals throughout the resident's daily activities. 3.9.1.1.2*
3.9.1.4
3.9.4.4*

Survey Report

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63. There should be sufficient, appropriately qualified staff to provide the various physical therapy services that are needed by the residents.

3.9.8*

3.10 Psychological Services

64. Sufficient psychological services should be provided to facilitate the optimal development of each resident. Such services should be rendered both directly, through personal contact between psychologists and residents, and indirectly, through contact between psychologists and other persons who are directly involved with the residents. Psychologists should participate, when appropriate, in the continuing interdisciplinary evaluation of individual residents.

3.10.1*

3.10.1.1.1*

3.10.1.1.2*

3.10.2*

65. The reporting and dissemination of evaluation results should be done in such a manner as to render the content of the report meaningful and useful to its intended recipient.

3.10.3.4.1*

66. Psychologists should help to design specific, detailed, and individualized habilitation programs for residents. These programs should be designed to maximize each resident's development, and should provide for periodic review, follow-up, and updating.

3.10.4*

3.10.4.1*

3.10.4.2*

67. There should be sufficient, appropriately qualified staff to carry out the various psychological services and activities that are necessary to meet the needs of residents, including evaluation, consultation, therapy and program development.

3.10.9*

3.10.9.1*

3.10.9.7 1*

3.10.9.6*

3.11 Recreation Services

68. The facility's statement of recreation objectives should be consistent with the philosophy and goals of the facility.

3.11.2.3*

69. Recreation activities should include activities for the nonambulatory, including the mobile and non-mobile.

3.11.4.18*

70. There should be sufficient, appropriately qualified recreation personnel to carry out the various recreation services that are needed by the residents.

3.11.12*

3.12 Religious Services

71. Those who serve the religious needs of residents should assert and safeguard the full human and civil rights of the residents.

3.12.6.1*

Survey Report

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3.13 Social Services

72. Social workers should participate, when appropriate, in the continuing interdisciplinary evaluation of individual residents. 3.13.8*
73. There should be sufficient, appropriately qualified personnel to carry out the various social service activities needed by the residents. 3.13.13*

3.14 Speech Pathology and Audiology Services

74. Speech and hearing services should be made available to residents. It is noted that such services are not presently available at the facility, and that residents have only very minimal access to such services elsewhere. 3.14.1*
75. As a minimum, there should be audiometric screening of all new residents, and also of any resident who is referred, with comprehensive audiological assessment whenever the need is indicated by screening results. There should also be speech and language screening of all new residents, and of all other residents, as indicated, with comprehensive speech and language evaluations when needed. 3.14.4.1.1*
3.14.4.1.4*
3.14.4.2.1*
3.14.4.2.3*
3.14.4.3
3.14.4.6
76. Qualified speech and audiology personnel should be available to participate in the continuing interdisciplinary evaluation of individual residents, as needed. 3.14.4.7
3.14.10*

3.15 Vocational Rehabilitation Services

77. The facility should provide all of its residents with habilitation and rehabilitation services that will insure the optimal development or restoration of each. 3.15.1*
78. Vocational rehabilitation services should be available to every resident. Pre-vocational services should contribute to the development of work readiness in the resident. 3.15.2*
3.15.7*
79. Vocational training programs should meet all applicable legal requirements. 3.15.8*
80. There should be sufficient vocational rehabilitation personnel to supervise the training of each resident involved in these programs. 3.15.8.8*

3.16 Volunteer Services

81. Volunteer services should be available to all residents. 3.16.3.4*

Survey Report

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4. Records

82. There must be for each resident a chronologically continuous record that documents an evaluation that identifies the specific developmental needs of the resident, and that specifies the program plan devised to meet the needs identified, with the program goals stated in behavioral terms. The record should report the response of the resident to the plan, and document his progress toward the goals. The record should also document the review and modification of the plan and goals in the light of the resident's progress. 4.1.1*
4.1.1.1*
4.1.1.2*
4.1.1.3*
4.1.1.4*
4.2.3.4*
83. The record for each resident should include a statement of the reason for his admission and his legal competency status. 4.2.1.5*
4.2.1.7*
84. Each resident's record should include reports of pre-admission evaluations. 4.2.1.12*
85. Within a period of one month after admission there should be recorded a review and updating of the preadmission evaluation, a statement of prognosis that can be used for programming and placement, a comprehensive evaluation and individual program plan designed by an interdisciplinary team, and a diagnosis based on the American Association on Mental Deficiency Manual on Terminology and Classification. 4.2.2.1*
4.2.2.2*
4.2.2.3*
4.2.2.4*
86. When a resident is discharged from the facility, the discharge summary should include a brief recapitulation of findings, events, and progress during residence, together with diagnosis, prognosis, and recommendations and arrangements for future programming. 4.2.4.1*
87. There should be sufficient, appropriately qualified staff to facilitate the accurate processing of records and record data. 4.6.1*

6. Safety and Sanitation

88. The requirements of the National Fire Protection Association Life Safety Code 1970 edition, should be met. 6.1.1*

SUMMARY AND CONCLUSIONS

The Mental Retardation Program of the Nevada Mental Health Institute is severely handicapped by physical facilities that are not well suited to a modern mental retardation habilitation program. Furnishings are inadequate and in poor condition. While some isolated attempts at improvement are evidenced in newly remodeled bathrooms and in some nicely decorated dormitories in one of the five wards, the overall physical environment is basically sterile and impoverished.

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The staffing of the mental retardation unit is extremely sparse. There are from two to four direct-care staff on the wards during the first two shifts, and one direct-care staff member on the wards during the third shift. Some badly-needed professional expertise, such as speech and hearing, is not represented at all on the staff that is available to the unit. Other professions, such as psychology and physical therapy, have less than one full-time staff member providing services to the program. The remainder of the special services, except for medicine and dentistry, do not have enough staff members to provide services to all the residents who need them. The foster grandparent program, with a staff of 12, does provide a variety of services to residents. Working four-hour shifts, five days a week, the program makes a valuable contribution to the mental retardation unit.

Programming decisions are made in one of three ways: direct intervention by medical personnel; contractual, cooperative agreements between ward personnel and special service staff; or team decisions by direct-care staff supervised by nursing personnel under the direction of the clinic administrator. None of these methods, of course, conform to the requirements for interdisciplinary evaluation and programming for each resident.

The staff does demonstrate a determination to improve services for the residents. In spite of only nominal community support and distressing physical conditions, it is encouraging to see this resource. It should be an invaluable asset to the envisioned progress of the program.

Considering the limitations of architecture, furnishings, and personnel resources available to the facility, it is unfortunate that no organized attempt is being made by community or parent organizations to meaningfully support the facility's staff in their attempt to secure additional resources.

Reference is made throughout this report to the Standards for Residential Facilities for the Mentally Retarded. Item numbers indicate Standards with which less than full compliance has been found. Category A items are indicated by *.

Rating by Accreditation Council, February 26, 1974: No accreditation.

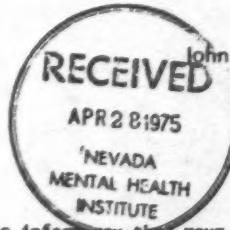
**Joint
Commission**
on Accreditation of Hospitals

875 North Michigan Avenue Chicago, Illinois 60611

J. S. KARALUK

April 18, 1975

Thomas A. Piepmeyer
Nevada Mental Health Institute
Box 2460
Reno, Nevada 89505



John D. Porterfield, M.D.

Director (312) 642-6061

Dear Mr. Piepmeyer:

The Joint Commission is pleased to inform you that your facility has been awarded two-year accreditation. This decision has been made by the Board of Commissioners upon review of the recommendations of the Accreditation Council for Psychiatric Facilities.

The Joint Commission considers accreditation maintenance as an ongoing educational activity, to be carried on throughout the two-year period for which your facility is accredited. For that reason, the Joint Commission has prepared the enclosed list of recommendations and comments based on what it believes to be the areas in need of further improvement. These recommendations might be considered your educational objectives in regard to accreditation and should be put into effect before the next visit by surveyors from the Accreditation Council for Psychiatric Facilities.

Copies of this letter with the recommendations are being mailed to the Chief of the Medical Staff and Chairman of the Governing Body of your facility, with whom this information must be shared. Since these recommendations are considered confidential on the part of the Joint Commission, their further release is a matter for your mutual consideration and decision.

Accreditation is not transferable. Any major change of name, ownership, control, merger, change in its capacity or in the category(ies) of service rendered, should be reported without delay to the Joint Commission for decision as to the maintenance of the facility's accreditation status. Failure to comply will jeopardize the accreditation status of the facility.

The Joint Commission wishes to commend you for maintaining standards deserving of accreditation and for your constant effort to improve the quality of patient care rendered by your facility. Should you have any questions concerning the accreditation status of your facility or the enclosed list of recommendations, please feel free to communicate with us at your convenience. Our staff will be pleased to help you in any possible way.

Sincerely,

John D. Porterfield, M.D.

John D. Porterfield, M.D.
Director

cc: Roger Trounsey, Chairman of the Governing Body
Victor J. LoCicero, M.D., Head of the Medical Staff
Surveyor: Robert T. Hewitt, M.D.
Survey Date: February 19-20, 1975

JDP:dd
Encls.

Member Organizations

American College of Physicians
American Hospital Association

American College of Surgeons
American Medical Association

Joint Commission 675 North Michigan Avenue Chicago, Illinois 60611
on Accreditation of Hospitals
Accreditation Council for Psychiatric Facilities

April 18, 1975

Jack W. White, D.B.A.
 Program Director (312) 642-6061

Thomas A. Pleyer
 Chief Administrative Officer
 Nevada Mental Health Institute
 Box 2460
 Reno, Nevada 89505

Dear Mr. Pleyer:

The Accreditation Committee of the Accreditation Council for Psychiatric Facilities was pleased to have the opportunity to recommend that Nevada Mental Health Institute receive accreditation for a period of two years. The Committee gave careful consideration to this matter and has directed that you be notified of an important point relative to the accreditation status of your facility:

According to Joint Commission policy, if an accreditation program recommends one-year accreditation or non-accreditation for one category of service, no other category of service shall receive more than one-year accreditation. Consequently, if the survey of the retardation service of your facility were to result in less than two-year accreditation for that service, then the period of accreditation for the entire facility would be reduced to one year.

We trust that your accreditation survey will be a positive influence in the provision of quality services to your patients and look forward to working with you in every way possible toward our common goal of serving the mentally ill.

Sincerely,

J. H. St. Louis

J.H. St. Louis, FACHA
 Division Director
 Psychiatric Hospitals Division

JWS/cw

cc: Victor J. LoCicero, M.D., Head of the Medical Staff
 Roger Trounsey, Chairman of the Governing Body

Council Members

American Academy of Child Psychiatry
 American Association on Mental Deficiency
 American Association of Psychiatric Services for Children
 American Hospital Association

American Psychiatric Association

Association of Mental Health Administrators
 National Association of Private Psychiatric Hospitals
 National Association of State Mental Health Program Directors
 National Council of Community Mental Health Centers

NEVADA MENTAL HEALTH INSTITUTERENO, NEVADADATE OF SURVEY

February 19-20, 1975

SURVEYOR

R.T. HEWITT, M.D.

REVIEWERSJOSEPH H. ST. LOUIS, FACIA
DEMETRA DEMONTERECOMMENDATIONS AND COMMENTSEnvironment

1. In buildings housing patients all toilets should have seats, with particular reference to Unit 9.

Dietetic Services

1. The dietitian or appropriate person should participate in clinical rounds and conferences.
2. The part-time dietitian should increase the numbers of consultation hours at the facility to provide better supervision for special diets.

Social Work Services

1. The organization plan should be updated at least annually.

Patient Education

1. All personnel should document their patient education services in the medical record.

Psychological Services

1. There should be available a sufficient number of appropriately qualified staff and necessary supporting personnel to provide psychological services.

Outpatient and Partial Hospitalization Services

1. There should be a written plan for the referral of patients for services not provided by the facility.

Pastoral Services

1. Pastoral services should have adequate funding to achieve its goals.

NEVADA MENTAL HEALTH INSTITUTE
RENO, NEVADA

PARTICULAR ATTENTION IS DRAWN TO THE MAJOR DEFICIENCIES OUTLINED ABOVE IN
RECTIONS:

ENVIRONMENT
DIETETIC SERVICES
PATIENT EDUCATION SERVICES
PSYCHOLOGICAL SERVICES
OUTPATIENT SERVICES
PARTIAL HOSPITALIZATION SERVICES
PHARMACEUTICAL SERVICES

THESE AND OTHER DEFICIENCIES MUST BE CORRECTED IN ORDER THAT ACCREDITATION
MAY BE MAINTAINED.

FOR A FULLER UNDERSTANDING OF THESE RECOMMENDATIONS, REFERENCE SHOULD BE
MADE TO:

ACCREDITATION MANUAL FOR PSYCHIATRIC FACILITIES

RATING BY BOARD OF COMMISSIONERS: TWO YEARS ACCREDITATION

Joint Commission 875 North Michigan Avenue Chicago, Illinois 60611
on Accreditation of Hospitals
Accreditation Council for Psychiatric Facilities

Walter Wolman, Ph.D.
 Program Director (312) 642-6061

June 27, 1975

Thomas A. Piepmeyer
 Nevada Mental Health Institute
 Box 2460
 Reno, Nevada 89505

Dear Mr. Piepmeyer:

As you recall, at the time of the JCAH Board of Commissioners' decision to accredit Nevada Mental Health Institute for two years, the Accreditation Committee of the Accreditation Council for Psychiatric Facilities also made known to you the Joint Commission's policy of granting no more than one year accreditation to a facility if one of the other categories of service receives less than two year accreditation. Since the mental retardation unit of Nevada Mental Health Institute received non-accreditation at the June 20, 1975 meeting of the Board of Commissioners, it is necessary to reduce the term of accreditation of Nevada Mental Health Institute from two years to one year.

Enclosed are recommendations for bringing your facility into compliance with the standards of the Accreditation Council for Facilities for the Mentally Retarded. AC/FMR is anxious to give you all possible assistance in your efforts to improve the services that your facility provides its residents. If you have any questions concerning the survey of the mental retardation unit, please communicate with Kenneth G. Crosby, Ed.D. Program Director, Accreditation Council for Facilities for the Mentally Retarded.

We were pleased to have the opportunity to survey Nevada Mental Health Institute and look forward to your continued interest in our program.

Sincerely,

J. H. St. Louis
 J.H. St. Louis, FACHA
 Division Director
 Psychiatric Hospitals Division

cc: Roger Trousday, Chairman of the Governing Body
 Victor J. LoCicero, M.D., Head of the Medical Staff

Council Members
 American Academy of Child Psychiatry
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 American Hospital Association

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 Association of Mental Health Administrators
 National Association of Private Psychiatric Hospitals
 National Association of State Mental Health Program Directors
 National Council of Community Mental Health Centers

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MENTAL RETARDATION PROGRAM
NEVADA MENTAL HEALTH INSTITUTE
RENO, NEVADA

SURVEY DATESSURVEYORS

Ann Hubbard, Ph.D.
 Michael Cook, M.S.

NOTE: The Mental Retardation Program of Nevada Mental Health Institute, initially surveyed in November, 1973, submitted a progress report concerning its implementation of the recommendations made in the report of that survey and its current self-assessment of compliance with the standards with which its compliance had been found to be deficient at that time. The present survey was directed to assessing the facility's current compliance with those standards, plus the additional standards now included under the Council's Topical Requirements for Accreditation. All standards with which the surveyors found the facility to be in less than full compliance are listed in this Survey Report, but the report does not list all of the previous deficiencies that have now been corrected by the facility.

RECOMMENDATIONS AND COMMENTS

STANDARDS
REFERRED TO

I. Provision of Active Rehabilitation Programming to Each ResidentA. General Requirements

- | | |
|--|--|
| 1. The facility remains unable to provide all the services needed to ensure the optimal development or restoration of each resident, physically, psychologically, socially, and vocationally. Deficiencies exist in the provision of certain aspects of normalized living experiences to all residents, especially residents of Unit 3 and services in speech development, education, psychology, recreation, and physical therapy are insufficient to meet the needs of the residents. The number of individuals admitted as residents should not exceed the facility's provisions for adequate programming. | 1.3.1.1.2*
3.15.1* |
| 2. Although there has been some effort to rearrange residents into more appropriate groupings, the total grouping of programs and residence units does not provide for small groups of residents of comparable developmental level and similar training needs. This is especially true in living Unit 3, whose residents represent a wide range of age and needs. The living unit groups are too large to ensure the development of meaningful relationships among residents and between residents and staff, and staff shortages, especially in Unit 3, preclude personnel from giving appreciable and appro- | 1.1.5.1*
2.1.1.1*
2.1.1.5*
2.3.1* |

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prists attention each day to each resident in the living unit. Rotation of staff in Units 1 and 5, and the need to borrow from other living units to cover staffing needs attest to the facility's current inability to provide the stability of staff that is necessary to facilitate the development of residents.

3. The daily menu should be posted in the dining/serving area where food is brought in each day. This is especially important since food service personnel are not involved in serving the food.

3.4.6.2*

B. Interdisciplinary Process Requirements

4. It is noted that the Mental Retardation Program staff are in the beginning stages of forming a viable interdisciplinary team that apparently will conform to the requirements of the Standards. Workshops concerning the interdisciplinary process have been held and appropriate membership on the team has been established. However, these new plans have only been in effect for approximately one month, and only one resident has been reviewed through this new interdisciplinary process. The "ward staffing conferences" in effect to this time, lack the participation of all relevant personnel and do not provide evidence that professional disciplines work together in a cooperative, coordinated, interdisciplinary way to meet the facility's objectives. It is noted that dental, food service, pharmacy, physical therapy, psychological, and religious services personnel will be expected to participate in the new interdisciplinary team process when their participation is relevant to the needs of the resident being considered. However, this is not true of the physician, who also serves patients in the facility's psychiatric program.

3.1.2.1*
3.1.2.3*
3.2.3.5*
3.4.3.5*
3.6.3.1*
3.8.3.4*
3.9.4.A PT.*
3.10.2*
3.12.6.2*

C. Evaluation and Program Planning Requirements

5. Considerable improvement has occurred in the facility's activities in accomplishing comprehensive interdisciplinary evaluations prior to admission and in following these up so that comprehensive evaluations are conducted and individual program plans developed for each resident, within one month after admission. However, at the time of the one month review, the team should develop a prognosis, as defined in the Glossary of the Standards, that can be used for programming and placement. In particular, the team should clarify the specific goals of the resident's habilitation program by stating these in behavioral terms.
6. There should be a regular, at least annual, joint review of each resident's status, and this review should include consideration of the advisability of continued residence and alternative programs.

(1.3.3*)
(1.3.3.1*)
(1.3.3.2*)
(1.3.3.3*)
(1.3.3.4*)
(1.3.3.6*)
(1.3.5.1*)
(1.3.5.2*)
(1.3.5.3*)

1.3.6*
1.3.6.1*

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7. There should be specific evaluation and program plans for each resident. 2.1.2.1*
8. Each resident's daily schedule should not permit "dead time" of more than one hour continuous duration, and this schedule should allow for individual or group free activities, with appropriate materials specified by the interdisciplinary team. 2.1.2.2.1*
2.1.2.2.2*
9. The consultant dietitian should conduct an initial and periodic evaluation of each resident's nutritional status, rather than attending only residents on a special diet. Diets modified in content or consistency should be prescribed, reviewed, and adjusted as needed by the resident's interdisciplinary team. 2.2.2.1.1*
2.2.2.1.2*
2.2.2.1.3*
3.4.3.1*
Currently, diets are prescribed only by the physician, with little consultation with any other persons, and diets are reviewed only at the suggestion of nursing or direct care staff. Diets are served by direct care personnel and foster grandparents who have had no training in preparing and serving food. It is suggested that the facility either train direct care personnel and foster grandparents in proper techniques of serving food, or that food service personnel assume this responsibility.
10. The facility has considerably improved its educational evaluation system: each resident receives an educational evaluation on admission, appropriate educational tests are utilized, the evaluations provide a basis for prescribing an individual learning program and promptly provide information useful to all staff working directly with the residents. The written educational objectives for each resident are based on data and are in specific behavioral terms, and relevant educational activities are conducted to accomplish the objectives. However, individual educational evaluations should be conducted for every resident at least annually, rather than just for those under 18 years old. (3.3.4.1*)
3.3.4.2*
(3.3.4.3*)
(3.3.4.4*)
(3.3.4.6.2*)
(3.3.5*)
(3.3.6*)
11. Psychological services should provide evaluation and assessment of individuals and programs, and evaluation results should be useful for the development of written, detailed, specific, and individualized habilitation program plans. It is noted that there are several residents, especially in Living Units 3 and 5, who manifest behavioral problems that would appear to require the attention of psychological personnel. 3.10.2.1*
3.10.3.4.1*
3.10.4*
12. All new residents and any resident referred should receive audiometric screening, and all residents should receive speech and language screening, as needed. There appears to be a lack of proper equipment to accomplish this screening, and an age limit of 21 years has been placed on residents who can receive speech and language screening. 3.14.4.1.1*
3.14.4.1.4*
3.14.4.2.3*

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D. Management of Program Delivery Requirements

13. The facility's organization should be such that problems requiring ongoing decision-making regarding the welfare of the resident are handled primarily by personnel on the lowest level competent to resolve the problem. At the present time, daily ongoing decisions, such as out-of-door activities for residents, can be blocked by other personnel unacquainted with the daily routine in the living units. 1.2.8.2.3*
14. There should be an activity schedule for each resident that is available to direct care staff and implemented daily. It is noted that some residents do have a full daily schedule. 2.1.2.2*
15. Each program group in the living unit should be assigned a specific person who is responsible for providing a developmental program of care, training, and recreation. Presently, program groups are not specified in the living units and lack of staff precludes carrying out an organized developmental program. 2.3.3.1*

E. Resident Training Requirements

16. Due to insufficient staff and the number of residents whose behavior problems are not under control, living unit staff still find it difficult to train residents in activities of daily living and in the development of self-help and social skills, especially in Unit 5. 2.1.1.2*
17. The resident's interdisciplinary team should establish his priority training needs. Then, each training program should specify the behavioral objectives of the training, the method to be used, the training schedule, the person responsible for conducting the training, and the data to be collected to assess progress toward the objectives. Such formal training programs should be available to all residents. Residents who need such training, should be trained to utilize freedom within and without the facility's grounds, use telephones and the mails, understand the value and use of money, and select and purchase their own clothing, preferably using community stores. Residents should also be trained to select their daily clothing and to have access to their own clothing. Accessible storage space for clothing should be provided residents. When residents are not able to manage access to their clothing, there should be formal training programs to teach them proper management. There should be formal training programs to train residents to bathe at the most independent level possible, and to utilize the living unit drinking units. Female residents should be trained to attain maximum independence in caring for menstrual needs. 2.1.1.2.1*
2.1.1.2.2*
2.1.3.4.1*
2.1.3.4.2*
2.1.5*
2.1.7.1.2*
2.3.2.1*
2.3.2.2*
2.3.3*
2.3.3.1.1*
2.4.1.5.1*
2.4.1.6*
2.4.3.1*

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F. Behavior Management Requirements

18. In almost every living unit, there are residents who are described as difficult to manage. There should be provision for the prompt implementation of appropriate and effective programs in all areas of the facility to eliminate the maladaptive behaviors that are defined as problems. The written statement of policies and procedures for the control and discipline of residents should be directed toward maximizing the growth and development of each resident, rather than merely establishing rules for the use of restraint and seclusion. These policies and procedures should be available in each living unit. It is suggested that the Mental Retardation Program design and obtain approval for a separate set of policies and procedures concerning behavior management, since the Nevada Mental Health Institute's policies and procedures apply to the psychiatric program and are not appropriate for the residents in the Mental Retardation Program.
- 2.1.8*
2.1.8.1*
2.1.8.1.1*
2.1.8.1.2*
19. Physical restraint should be used only when absolutely necessary and never for the convenience of staff or as a substitute for program. Due to lack of staff in some areas, deficiencies in special services, and lack of individualized program plans to eliminate maladaptive behavior, restraints are being used. It should be noted that a "soft restraint" is still a restraint and its use must be governed by the standards relating to restraints. Restraint orders should not be in force for more than twelve hours and standing or PRN orders should not be used. Residents placed in restraints should be checked at least every thirty minutes by trained staff, and a record of such checks should be kept. Opportunity for motion and exercise should be provided for not less than ten minutes during every two hours in which the resident is in restraint. When physical restraint is used, it must be an integral part of an individual program plan that is designed by the interdisciplinary team to lead to a less restrictive way of managing, and ultimately to the elimination of the behavior for which the restraint is applied. The individual's program plan should specify the behavior to be eliminated, the method to be used, the schedule for use of the method, the person responsible for the program, and the data to be collected to assess progress toward the objectives. The resident's record should record all periods of restraint, with justification and authorization for each period.
- 2.1.8.6*
2.1.8.6.1.1*
2.1.8.6.1.1.1*
2.1.8.6.1.2*
2.1.8.6.1.4*
2.1.8.6.3*
2.1.8.6.3.1*
4.2.3.2*
20. Medication should not be used for the convenience of staff, as a substitute for adequate programming, or in quantities that interfere with the resident's habilitation program. Behavior modifying drugs should be used only as an integral part of an individual program plan that is designed by the interdisciplinary team to lead to a less restrictive way
- 2.1.8.8*
2.1.8.8.1*
2.1.8.8.1.1*

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of managing, and ultimately to the elimination of, the behavior for which the drugs are employed. The program plan should specify the behavior to be modified, a time-limited prescription by a licensed physician, and the data that are to be collected in order to assess progress toward the treatment of objectives.

21. When problem or maladaptive behaviors are to be modified, the resident's program plan should include provisions to teach the resident the circumstances under which the behaviors can be exhibited appropriately, to channel the behaviors into similar but appropriate expressions, or to replace the behaviors with behaviors that are adaptive and appropriate. Similar to the standards concerning restraint, the plan must specify the behavioral objectives of the training program, the method to be used, the schedule for use of the method, the person responsible for the program, and the data that are to be collected in order to assess progress toward the objectives. Whenever restraint, behavior modifying drugs, or behavior modifying techniques involving the use of aversive stimuli are employed to eliminate maladaptive or problem behaviors, the resident's record should reflect the fact that less restrictive methods of modifying or replacing the behavior have been systematically tried and have been demonstrated to be ineffective.
- 2.1.8.10*
2.1.8.10.1*
2.1.8.10.2*

G. Attention to Resident Health Needs Requirements

22. Since the only physician assigned to the Mental Retardation Program has additional commitments to patients in the psychiatric program of the institute, his time with the residents and their interdisciplinary teams, is limited. Therefore, medical services can neither achieve and maintain an optimal level of general health for each resident nor maximize the normal function and prevent disability of residents who are at risk of further loss of function. It is noted that additional medical personnel have been requested to provide the needed services.
- 3.6.1
3.6.1.1*
3.6.1.2*
23. Each resident's annual physical examination should include an assessment of the resident's ability to see and to hear.
- 3.6.9.2.1*
24. Residents should be provided with nursing services, in accordance with their needs, in order to encourage maximum self-care and independence. Presently, there is a need for health assessments, written health care programs, and adequate nursing care for ambulatory residents, other than distributing medication and taking care of emergencies. There should be adequate nursing care plans for preventing disability, especially with the low-functional-level residents in Living Unit 1.
- 3.7.1*
3.7.1.3*
3.7.4.3*
25. Additional qualified professional personnel are needed to adequately supervise the use of mechanical supports so that all supports reflect concern for good body alignment, circulation,
- 2.1.8.7.1*
2.1.8.7.2*
2.1.8.7.3*

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and allowance for change of position. The use of a mechanical support should be specified in the resident's program plan.

H. Rehabilitation Services Requirements

26. Since the present social worker neither possesses the qualifications required for independent practice nor receives supervision from qualified social workers, ethical standards of professional conduct, as developed by the National Association of Social Workers, are not being upheld in the facility. 1.4.2.4*
3.13.13.7
27. Deficiencies in speech pathology and audiology, education, psychology, recreation, and physical therapy prevent compliance with the requirement that services be provided so that the optimal development of each resident can be realized. Educational services are available only to residents between the ages of 5 and 18, rather than to all residents, regardless of level of retardation, age, or physical disability. Since there is only one physical therapist serving the entire facility, including the geriatric and psychiatric populations, these services are not available to all residents who could benefit from them. Psychological services are needed to achieve the optimal development of each resident, especially residents displaying behavioral problems in Living Units 3 and 5. The facility finds it difficult to provide recreational services for each resident, unless direct-care staff work overtime so that residents can attend programs. Religious services should be available to residents, in accordance with their needs, desires, capabilities, and basic right to freedom of religion. At the present time, staff is not sure of the needs of the residents nor has it determined the desires of the residents or their parents. Speech and hearing services are not available to residents over the age of 21, and some residents under 21 who need these services are not able to receive them. 3.1.1*
3.3.1*
3.9.1.1.2 PT.*
3.10.1*
3.11.1*
3.12.1*
3.14.1*
28. There should be a current, written policy encouraging resident training for productive, paid employment. The facility should develop a system whereby the ultimate objective of vocational rehabilitation services would be to assist every resident to move as far as he can along the continuum from vocational dysfunction to remunerative employment and entry into the mainstream of society as an independent citizen and worker. At the present time, there is a lack of prevocational services to develop work readiness in residents. 1.4.6.2*
3.15.2*
3.15.7*
29. Food services personnel should either be responsible for serving food in the dining/serving areas on the living units in order to maintain sanitary standards or they should adequately supervise trained direct-care and foster grandparent personnel in serving. 3.4.4.6*

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I. Staff Training and Consultation Requirements

30. Formal training programs should be developed to train direct-care staff and foster grandparents to utilize proper feeding techniques. It is suggested that when an interdisciplinary team is considering approaches to mediating the feeding difficulties of a resident, the foster grandparent feeding that resident should be a member of the team. 2.2.4.2*
31. Psychologists should provide intensive training to living unit staff in changing and modifying behavior, so that staff can meet their responsibilities to the residents in the areas of training and managing maladaptive behaviors. 3.10.1.1.2*

J. Staffing Requirements

32. There is still insufficient staff in the resident living units to carry on programs as required by the Standards. Additional food service staff is necessary to adequately supervise the serving of food to the residents, and the dining room should be sufficiently staffed for the direction of self-help eating procedures and to assure that each resident receives an adequate amount of food. Additional education, nursing, physical therapy, psychology, recreation, religious, social services, and speech and hearing staff are needed to provide each resident with the necessary and appropriate evaluation and therapy services. 2.2.3.4*
2.6.1*
3.3.8*
3.4.12*
3.7.7*
3.9.8 PT.*
3.10.9*
3.11.12*
3.12.7
3.13.13*
3.14.10*

K. Documentation Requirements

33. As previously noted, the facility is beginning to utilize an interdisciplinary process which includes a comprehensive evaluation of each resident. This process, however, has not yet been completed, and the results have not yet been entered in the record of every resident. Similarly, a specific habilitation program plan devised to meet the resident's needs, with goals stated in behavioral terms, is not available for every resident. The results of the annual, joint review should be recorded in the resident's record, and data should be collected concerning at least the resident's priority training needs with sufficient frequency to determine the progress of the resident and the effectiveness of his program. 4.1.1.1*
4.1.1.2*
4.2.3.3*
4.2.3.4*

L. Facilities and Equipment Requirements

34. Provisions should be made to furnish and maintain in good repair, and to encourage the use of, hearing aids, eyeglasses, and other prosthetic devices necessary to increase the competence of residents. Presently, staff seems to show little concern when such devices are lost and become unavailable to residents. 2.4.7*

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35. The design and furnishing of the living units should be appropriate to a program based on normalized living, developmental orientation, and intensive training. Toilets, showers, tubs, lavatories, and closets should be located to facilitate training toward maximum self-help by residents, including the severely and profoundly retarded and the multiply-handicapped. Lack of appropriate living unit design and furnishings continues to hinder resident living and programming in all living units except Unit 2. Food service facilities are inadequate for serving food in the dining/serving areas on the living units. The facility should improve the physical arrangements for serving food, in order to maintain proper sanitation and food temperatures. It is suggested that the steam table that is available in one dining/serving area be utilized as soon as possible.
- 2.7.1.2*
2.7.5*
3.4.15.1.4*

II. Provision of Services Within a Normalized and Normalizing EnvironmentA. General Normalization Requirements

36. The facility accepts and attempts to implement the principle of normalization. However, with the exception of some improvements in Living Unit 4, it has been unable to modify the environments in which the residents live so as to be in compliance with this standard. Although the name of the facility has been changed from "state hospital" to "mental health institute", there are still individuals who refer to the facility as a hospital and to the living units as wards. Staff should refrain from calling adult residents "children" or "patients", and residents residing in Living Unit 1 should not be called "babies", when they are not infants.
- 1.1.1.1*
1.1.2*
1.1.2.1*
37. Food left on regular tables for up to two hours before being served to residents is neither appetizing nor at the proper temperature. As suggested previously, the steam table that is not being utilized should be reactivated as soon as possible.
- 2.2.2.7.4*
38. Residents should wear their own clothing. The sharing of underwear and socks in Units 2, 3, and 5 should be discontinued.
- 2.3.1.1*
39. Menstrual supplies should be of the same diversity available to all women in the community.
- 2.4.1.6.1*

B. Community Integration Requirements

40. Residents should attend community religious programs whenever possible.
- 1.1.4.2

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41. In accordance with the normalization principle, professional services in the community should be used as extensively as possible. When services are rendered in a residential facility, these services should be at least comparable to those provided the nonretarded in the community. The adult education and speech therapy services provided in the facility are not comparable to those provided in the community.

3.1.1.2*

C. Integration of Multihandicapped Requirements

42. Toilets and bathing appliances should be equipped for use by the physically handicapped. There should be at least one toilet in the living unit that is accessible to residents in wheelchairs.

2.7.5.3*
2.7.5.4.1*D. Rhythm of Life Requirements

43. The pattern of living in the living unit should resemble that of nonretarded persons of the same age living in the community, unless departures are justified on the basis of maximizing the development of the residents. Presently, there is very little individualization. Residents must arise at approximately 5:30 to 6:00 o'clock in the morning and there is no change in this schedule on weekends or holidays.
44. Multiply handicapped and nonambulatory residents should spend at least 25% of their waking day out of their bedroom area and be rendered mobile by various methods and devices. Since Living Unit 1 is a bedroom area for nonambulatory residents, it is difficult to get the residents away from the area except at meal times and for limited special activities. Additional specialized or customized mobility equipment is needed to move residents to other areas.
45. All residents should have planned periods out of doors on a year-round basis, weather permitting. Birthdays should be individually observed. There is sometimes as much as 16 hours between a resident's evening meal and the following breakfast. It is suggested that meals be scheduled so that this situation does not occur.

2.1.3*

2.1.3.2.2*
2.1.3.2.4*2.1.3.3*
2.1.3.5*
2.2.2.4.2*E. Physical Environment Requirements

46. Despite conscientious efforts on the part of staff, the lack of staff, especially in Living Units 3 and 5, precludes the maintenance of a warm, family- or home-like environment that is conducive to optimal development of the residents. The living units should be arranged to simulate a home and encourage a personalized atmosphere for small groups. The lack of furniture

2.1.1.3*
2.2.3.2.3*
2.4.1.5.2*
2.5.4*
2.7.2*
2.7.2.3*

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and furnishings in some living units creates a sterile, hospital-like environment. Similar to a home situation, residents should be allowed free use of all living areas within the living units, with due regard for privacy and personal possessions. Residents continue to eat in large central dining areas, rather than in normalized, home-like areas. Although most residents have some personal storage space, a few do not yet have wardrobe cabinets for their clothing nor places to store their personal play equipment or individually prescribed prosthetic equipment. Although staff has provided privacy curtains and doors in some living-unit toilet areas, individual privacy is not provided for toilets, bathtubs, and showers in all areas. The practice of group bathing, for example, in Unit 2, prevents bathing being conducted with due regard for privacy. The arrangement of toilets, showers, bathtubs, and lavatories should approximate normal patterns in homes, and toilet tissues should be readily accessible at each toilet.

2.7.3.9.1*
2.7.3.9.2*
2.7.5.1*
2.7.5.2*
2.7.5.4.3*

III. Assurance of Rights of Residents and their FamiliesA. General Rights-Assurance Requirements

No deficiencies noted.

B. Rights of Residents Requirements

47. When a resident attains majority, or if he becomes emancipated prior thereto, his annual, joint review should include consideration of his need for remaining in the facility, his need for guardianship, and the exercise of his civil and legal rights.
48. Participation in religious programs and practices should be voluntary, in accordance with the wishes of the resident, if he can express them, or with the wishes of his parents or guardians. Staff is presently in the process of discovering the desires of the resident and/or his parents concerning this issue.

1.3.6.2.1*
1.3.6.2.2*
1.3.6.2.3*

3.12.4.1*

C. Rights of Families Requirements

49. The written policy concerning visiting hours for relatives should be revised, and relatives should be allowed to visit at any reasonable hour, and without prior notice. Policies and procedures on control and discipline should be available to parents or guardians.

1.2.11.8*
2.1.8.1.3*

IV. Effective Administrative PracticesA. General Administrative Requirements

50. Adequate, modern administrative support from the state

7.1.1*

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level should be provided to efficiently meet the needs of, and contribute to, program services for residents, and to facilitate attainment of the goals and objectives of the facility. It is evident that the austerity freezes have severely affected the provision of adequate services to the residents, and if funding remains low and staffing requests are not granted, the facility will continue to find it difficult to provide even minimal services for residents.

E. Communication Requirements

No deficiencies noted.

C. Records Requirements

51. There is a need for a more formal and systematic method of collecting and recording accurate data that describe the population. 1.2.9.7*

D. Research Requirements

No deficiencies noted.

V. Maintenance of a Safe and Sanitary Environment Requirements

52. There should be handwashing facilities with hot and cold water, soap, and paper towels adjacent to each food service area in the living units. 2.2.5.1*
53. The requirements of the National Fire Protection Association Life Safety Code, 1970 Edition, are not met at this time, as explained in the progress report submitted by the facility. Similarly, strict compliance with fire safety requirements has not been achieved. 6.1.1*
6.1.2*
54. Every person engaged in the serving of food, including direct care personnel and foster grandparents should annually be medically determined to be free of any disease in a communicable stage. 3.4.12.6.1

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CONCLUSION

The Mental Retardation Program of the Nevada Mental Health Institute has continued its difficult evolution toward achieving a developmental and training orientation for meeting the needs of its residents. Once the stepchild of a larger psychiatric program, the Mental Retardation Program has made considerable progress in establishing its own identity. It is hoped that, with the guidance of a new administrator and with financial support from the state, this program will eventually be able to provide the services necessary to meet the needs of all its residents.

Difficulties still remain due to insufficient staff at both the direct-care and professional levels, as well as inadequate living unit design and furnishings. Progress has been made in Unit 4, where residents enjoy a more home-like atmosphere and maintain their own possessions, but Units 3 and 5 still lack the barest semblance of a home-like or normalizing environment.

Staff are enthusiastically undertaking a new interdisciplinary process which should, in time, bring the facility into compliance with the standards regarding the team's membership and function.

The community is becoming more aware of the needs of the residents in the program, and hopefully, will be helpful in persuading state officials to provide adequate funding for better staffing ratios and better living conditions for the residents.

Reference is made throughout this report to the Standards for Residential Facilities for the Mentally Retarded. Item numbers not enclosed in parentheses indicate Standards with which less than full compliance has been found. Category A items are indicated by an asterisk.

Rating by Accreditation Council, June 11, 1975. No accreditation.

Appendix C

CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

CALIFORNIA'S CHILD HEALTH AND DISABILITY PREVENTION PROGRAM*

Parents of children beginning the first grade in the fall of 1975 will have to present to their school a CHDP Program Certification for School Entry, which is verification by the screening provider(s) that the child has received all or the equivalent of all of the required health screening services, or that the parents have decided not to have their child receive the health screening services.

CHILD HEALTH AND DISABILITY PREVENTION PROGRAM PURPOSES

The purposes of the CHDP Program are:

- To provide early and periodic assessments of the health status of children who are Medi-Cal beneficiaries under the age of 21, and of children who are entering 1st grade in the fall of 1975;
- To provide that on and after July 1, 1975, each child eligible for services, before enrollment in the 1st grade, shall have the opportunity to receive an efficiently provided health screening evaluation that is of the highest quality;
- To prevent physical and mental disabilities in children;
- To provide for the early identification and referral for treatment of children with potential handicapping conditions before they become chronic and irreversible damage occurs, and/or to lessen their impact on individuals so afflicted;
- To benefit the health and welfare of the citizens of this State by reducing the incidence of such conditions;
- To make maximum use of existing health care resources so that health screening programs are fully integrated with existing health services, that health care professionals be appropriately represented and utilized in these programs, and that outreach programs be developed to stimulate the use of such preventive health services.

DEFINITIONS

For the purposes of the Child Health and Disability Prevention Program, the following definitions apply:

Child Health and Disability Prevention Program

"Child Health and Disability Prevention Program" means all activities including, but not limited to, planning, outreach and health education, periodic screening, referral for further diagnosis and treatment, follow-up, recordkeeping, evaluation, and fiscal procedures related to a community-based program of early identification and referral for treatment of children with potentially handicapping conditions.

Outreach and Health Education Services

"Outreach and health education services" means the methods, including but not limited to simple notification, by which the eligible population is informed of the nature, scope and benefits of the program, and is motivated to participate in it. Outreach and health education services shall be designed to insure that the only reason eligible individuals do not participate in the program is because they intelligently and knowingly decline such participation for reasons unrelated to availability and accessibility of the health screening services.

Screening

"Screening" means the use of simple procedures to sort out from apparently well persons those who have suspected disease or abnormality and to identify those in need of more definitive study of potential physical, mental or other health problems.

*Material in this appendix was prepared by the Department of Health, Health and Welfare Agency, State of California, Sacramento, 1975. For more details see the Administrative Regulations for this program filed with the California Secretary of State, February 27, 1975 (Calif. Administrative Code, Title 17, Chapter 4, Subchapter 13).

Diagnosis

"Diagnosis" means the determination of the nature of a disease or disorder suspected as a result of screening.

Treatment

"Treatment" means the management and care of a child for the purpose of preventing or combating disease or disorder.

Early

"Early" means as soon as possible in the child's life in accordance with the regulations.

Periodic

"Periodic" means health screening repeated at appropriate intervals in accordance with the regulations.

Referral

"Referral" means the educational process by which the family understands the need for further diagnosis and treatment, and is assisted in obtaining the necessary diagnosis and treatment.

Follow-Through

"Follow-through" means the mechanism for confirming completion of the necessary diagnosis and treatment.

SCREENING SERVICES

The health screening services to be offered can be summarized as follows:

- **Screening Evaluation of Health Status (SEHS)**
The SEHS will consist of collecting all available health information about the patient. The SEHS includes a history, physical examination, and dental and nutrition assessments.
- **Developmental Assessment**
The developmental assessment shall be done by means of the (1) Denver Developmental Screening Test or (2) the approved alternate method in the community plan or (3) by less formal means for children who have been receiving continuous care by their physician for a minimum of six months.

- **Immunizations, as needed, including:**

DTP — Diphtheria and tetanus toxoids combined with pertussis vaccine.

TOPV — Trivalent oral polio virus vaccine.

MMR — Measles, mumps and Rubella, individually or in combination.

TD — Combined tetanus and diphtheria toxoids.

- **Tuberculin Testing**, by means of a standardized PPD or a tine test.

- **Laboratory Tests**, including blood tests for anemia, phenylketonuria (PKU), syphilis, sickle cell disease (when appropriate) and lead (under special conditions), and urine tests for sugar, protein and blood.

- **Vision Screening**

Vision screening shall consist of a history of eye problems, an inspection of the external eye, evaluation for strabismus, evaluation of the retinal (red) reflex, and in children who are mature enough to cooperate, screening for far visual acuity by means of a Snellen test. If conducted by a licensed optometrist or ophthalmologist, the Modified Clinical Technique (MCT) may be used.

- **Hearing Screening**

Hearing screening shall be appropriate to the age of the child. For children under 3 years of age, it shall be part of the SEHS, noting behavior of the child in response to sound as well as noting problems in speech and language development. For children over 3 years of age who are mature enough to cooperate, hearing screening shall be an individual pure tone audiometric screening test.

ELIGIBILITY DETERMINATION AND/OR VERIFICATION FOR STATE REIMBURSEMENT

In fiscal year 1974-75, the State will reimburse providers for screening services administered to Medi-Cal beneficiaries under 21 years of age and to those children entering first grade in September 1975.

who are not eligible for Medi-Cal, but whose gross annual family income is at or below twice the AFDC minimum basic standard of adequate care (CHDP eligible).

Medi-Cal Eligibility

Medi-Cal eligibility is verified by obtaining a POE label or a copy of the child's Medi-Cal ID card which is valid for the month in which the service is rendered. The POE label or the copy of the valid ID card should be attached to the Confidential Screening/Billing Report.

CHDP Eligibility

CHDP eligibility is determined with the use of the CHDP Eligibility Determination Table (Attachment A). The provider informs the parent or guardian that the child may be eligible for State reimbursement for screening services if the family income meets certain standards. The CHDP Eligibility Determination Table is given to the parent and the parent compares his family size with the gross annual (or monthly equivalent) family income specified in the Table for that family size. If the family income is at or below the level specified in the Table, the parent reports this to the provider and the child is eligible for State reimbursement for the screening services.

CHDP eligibility is verified when the parent or guardian completes the Eligibility Verification statement on the Confidential Screening/Billing Report.

USE OF THE CONFIDENTIAL SCREENING/BILLING REPORT

The Confidential Screening/Billing Report (PM 180) is designed to provide both billing and statistical information to state and local CHDP programs. Providers billing the state for screening services administered to Medi-Cal or CHDP eligible children are to use the PM 180. Fees for screening services are listed in Article 9 of the enclosed CHDP Program regulations.

A sample PM 180 with billing instructions on the reverse is included as Attachment B (tear-out). The actual Screening/Billing Report is a seven-part form and will be distributed by community CHDP programs located in local health departments.

The Screening/Billing Report is also to be used as an optional report of screening services provided to private pay patients in the CHDP Program. Instructions for submission of statistical information only are on the back of the Report.

REFERRALS FOR DIAGNOSIS AND TREATMENT

When a screening provider determines that a child needs diagnosis or treatment, the first referral is to be to the child's usual source of health care. If a referral is required and no regular source of health care can be identified, the screening provider must provide a list of at least three appropriate sources of care and assist in making an appointment. The screening provider is responsible for providing assistance, either directly or by agreements with appropriate agencies or individuals, to assure that referrals are completed. A screening provider may make self-referrals for diagnosis and treatment.

USE OF THE CONFIDENTIAL REFERRAL/FOLLOW-UP REPORT

Screening Provider

The screening provider is to complete the top half of a Confidential Referral/Follow-up Report (PM 181) for each patient referred for diagnosis and treatment. If the patient is referred to more than one provider, a separate PM 181 must be completed for each provider. A Referral/Follow-up Report must be prepared even if follow-up will be done by the screening provider.

The screening provider is to give the last 3 copies of the Referral/Follow-up Report to the parent, guardian, or emancipated minor for transmittal to the provider to whom the patient is referred. A sample Referral/Follow-up Report with instructions is included as Attachment D. The actual Report is a five-part form and will be distributed by community CHDP Programs.

Provider of Diagnostic and Treatment Services

The provider of diagnostic and treatment services is to complete the bottom half of the Referral/Follow-up Report and mail the last copy to his local CHDP program in a self-addressed envelope. To bill Medi-Cal for diagnostic services, he may submit a copy of the Referral/Follow-up Report with proof of Medi-Cal eligibility (POE label) in lieu of Medi-Cal prior authorization.

CHDP PROGRAM PARTICIPATION

Providers who wish to participate in the CHDP Program should read the enclosed information and review the regulations. Participation may be accomplished in several ways:

- Providers who wish to obtain state reimbursement for screening services must

submit one copy of the Agreement to Participate as a Provider (Attachment B - tear-out) to their community CHDP program. A list of community CHDP program addresses is enclosed as Attachment F.

- Agencies, organizations, and individuals establishing screening operations must also submit the additional information described on Attachments A and B to the Agreement to Participate as a Provider (Attachment C).
- Providers meeting program regulations will be approved as CHDP providers by their community CHDP program directors.
- Approved CHDP providers who have Medi-Cal provider numbers must use them to bill for screening services. Providers who do not have Medi-Cal provider numbers will be assigned CHDP provider numbers for billing at the time they are notified of approval.
- Providers who do not wish to obtain state reimbursement for screening services, but who do wish to certify children for school entry must notify their community CHDP program of their intent to provide the required screening services. They must also inform themselves about the requirements of CHDP program regulations.
- Providers who wish to participate as referral resources for diagnosis and treatment only are requested to submit the Agreement to Participate as a Provider to their community CHDP programs to assist them in estimating the adequacy of resources for diagnosis and treatment of disabilities suspected as a result of screening.

Please direct all questions about becoming a CHDP provider to the community CHDP program located in your local health department. See Attachment F for a list of community CHDP program addresses.

CONDITIONS FOR PARTICIPATION

Each screening provider shall forward to state and community CHDP programs all required reports on a timely basis.

Each screening provider who performs the Screening Evaluation of Health Status (SEHS) and wishes to submit a Screening/Billing Report to state and local

CHDP programs shall issue Child Health Identification Cards to participants in the program. These cards are for identification only and do not serve as proof of eligibility for CHDP program reimbursement. Child Health Identification Cards will be distributed by community CHDP programs.

Each screening provider shall provide the child or his parent or guardian with a copy of the results of the health screening and evaluation, an explanation of the meaning of the results, and a separate certification of having received such screening services.

Each screening provider shall make arrangements for referral for diagnosis and/or treatment for all children identified as needing such services. Such arrangements shall be made as specified in Article 7 of the CHDP Program regulations.

Each screening provider shall determine the financial eligibility of persons seeking health screening services, and bill in accordance with the provisions of the CHDP Program regulations.

Prepaid health plans under contract with the State of California within the provisions of California Administrative Code, Title 22, Division 3, Article 8, shall, unless specifically exempted from doing so, meet the standards in this Article, and shall provide CHDP Program services to all Medi-Cal beneficiaries under 21 years of age that are enrolled in such prepaid health plans. Medi-Cal prepaid health plans may offer CHDP Program services to nonenrollees and shall notify the community CHDP Program director in writing of their intent to offer services to nonenrollees.

Each provider of screening services shall insure that:

- Screening services shall be made available to eligible children as defined in the CHDP Program regulations upon referral from any source, including self-referral, without regard to race, religion, sex, national origin, citizenship, marital status, or parenthood.
- Acceptance of screening services shall be voluntary, although outreach programs shall be designed and implemented by the State and communities in order to encourage maximum utilization of such services. Screening services shall not be provided to minors without

obtaining written consent from their parent or guardian.

- Screening services shall be provided in a manner that respects the privacy and dignity of the individual. Children receiving State subvented screening services shall not be treated in such a way that they are identifiable from the rest of the population served.
- All information obtained by the screening agency staff as to personal facts and circumstances pertaining to eligible children and their families shall be treated as privileged communication, shall be held confidential, and shall not be divulged without written consent, except as may be necessary to provide emergency services to the child, or as required by the department to administer this program.
- Every effort shall be made to have one or both parents, or the guardian present during the screening procedure of minors, except in the case of emancipated minors.
- In order to make services accessible, screening clinics shall be scheduled at times convenient to working parents such as during evenings or on weekends.

- Bilingual staff shall be available whenever necessary to provide effective and efficient communication with children and parents who have difficulty with English.

CERTIFICATION FOR SCHOOL ENTRY

The Certification for School Entry (and Waiver) is to be completed by the screening provider(s) and/or the child's parent or guardian. It is either to be mailed directly to the child's school by the screening provider or given to the parent to be mailed or carried to the school.

Providers who submit the Agreement to Participate as a Provider and are approved by their community CHDP Program will receive Certification for School Entry Forms from their community CHDP Programs.

Providers who do not intend to bill the State for screening services but who wish to certify children for school entry must request Certification for School Entry forms from their community CHDP programs.

A copy of the Certification for School Entry (and Waiver) is enclosed as Attachment E.